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ABSTRACT

This document contains six papers from the ninth World Conference of Therapeutic Communities that highlight research on therapeutic communities (TC) and discuss how to apply research findings in practical ways. Papers include: (1) "TC Research: Overview & Implications" (George De Leon); (2) "Emerging Cross-Cultural TC Research" (D. Vincent Biase and Arthur P. Sullivan); (3) "Follow-up of the Former Residents of the Emiliehoeve, a TC for Drug Addicts" (Martien Kooyman); (4) "Lasting Effects: Detoxification from Methadone Maintenance in a TC" (James I. Sorensen, et al.); (5) "Circumstances, Motivation, Readiness & Suitability: Do These Factors Relate to Treatment Tenure in TCs?" (George De Leon and Nancy Jainchill); and (6) "Juvenile Drug Addiction: A Study on Typology of Addicts and Their Families" (Luigi Cancrini, et al.). (NB)

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CHAPTER 3

TC RESEARCH: STATE OF THE ART

THERAPEUTIC COMMUNITY RESEARCH: OVERVIEW AND IMPLICATIONS

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Recent years have witnessed a burgeoning of research and evaluation in therapeutic communities. The emphasis of this work has been on treatment outcome, with fewer investigations of retention and treatment process. This paper provides an overview of the main findings and conclusions from this research. Implications for treatment, theory and further research are discussed, particularly with respect to the changing profile of substance abusers entering therapeutic communities.

The literature is not exhaustively surveyed, nor is it critically reviewed. Although attention was placed on recent research, the bibliography includes references that extend back to 1969. With few exceptions, the papers cited in the text are those reported after 1977. Much of the material in this review is drawn from De Leon (1984a).

Treatment Outcome

The effectiveness of therapeutic communities has been evaluated primarily through followup studies. Many of these have been executed by investigative teams engaged in large scale modality comparisons that include therapeutic communities. Others have been conducted on and by individual TCs. Most studies utilized self report which was considered reliable, although several contain corroborating çinformation from outside agencies.

Social Adjustment. All of the studies revealed that immediate and long term outcome status of the clients followed are significantly improved over pre-treatment status. Drug use and criminality declined while measures of prosocial behavior (employment and/or school involvement) increased (e.g., Barr and Antes, 1981; Brook and Whitehead, 1980; De Leon, 1984a, De Leon et. al., 1979; Holland, 1978; Pompi et al, 1979, Wilson and Mandelbrote, 1978, Simpson and Sells, 1982).

A few studies have utilized a composite index of successful out come, combining measures of criminal activity, drug use and employment. In these, maximally or moderately favorable outcome occurred in approximately half the clients followed (De Leon, 1984a, Simpson and Sells, 1982).

Psychological Adjustment. Although a primary goal of therapeutic communities is psychological adjustment, this domain appears in few outcome studies (e.g., Brook and Whitehead, 1980; De Leon, 1984a; De Leon and Jainchill, 1981; Kennard and Wilson, 1979). In these, psychological scores or profiles significantly improved at followup.

Phoenix House studies have also demonstrated a direct correlation between social adjustment (success rates) and psychological adjustment at two year followup (De Leon, 1984a; De Leon and Jainchill, 1981).

Time in Program. Studies which examined differences between clients who complete (graduates) and those who drop out of treatment indicated that the graduates were significantly better than dropouts on all measures of outcome. The investigations that analyzed time in çprogram (TIP) reported a positive relationship between favorable outcome and length of stay in treatment among dropouts (See Figure 1) (e.g., Barr and Antes, 1981; Coombs, 1981; De Leon, 1984a; Holland, 1983; Simpson and Sells, 1982; Wilson and Mandelbrote, 1978).

Who Are the Successes?. Research has yet to delineate a client profile that predicts successful outcome. Age, race and other demographic factors do not relate to outcome in TCs. In Phoenix House research, females do yield significantly better psychological adjustment than males at followup (De Leon and Jainchill, 1981). However, this difference in psychological outcome by sex remains to be replicated in other programs.

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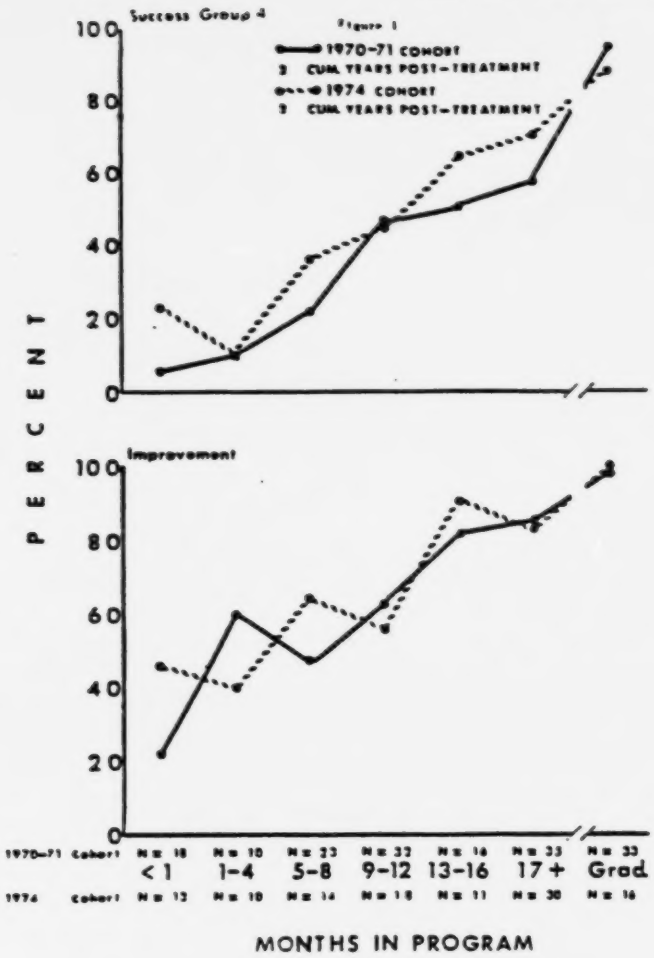
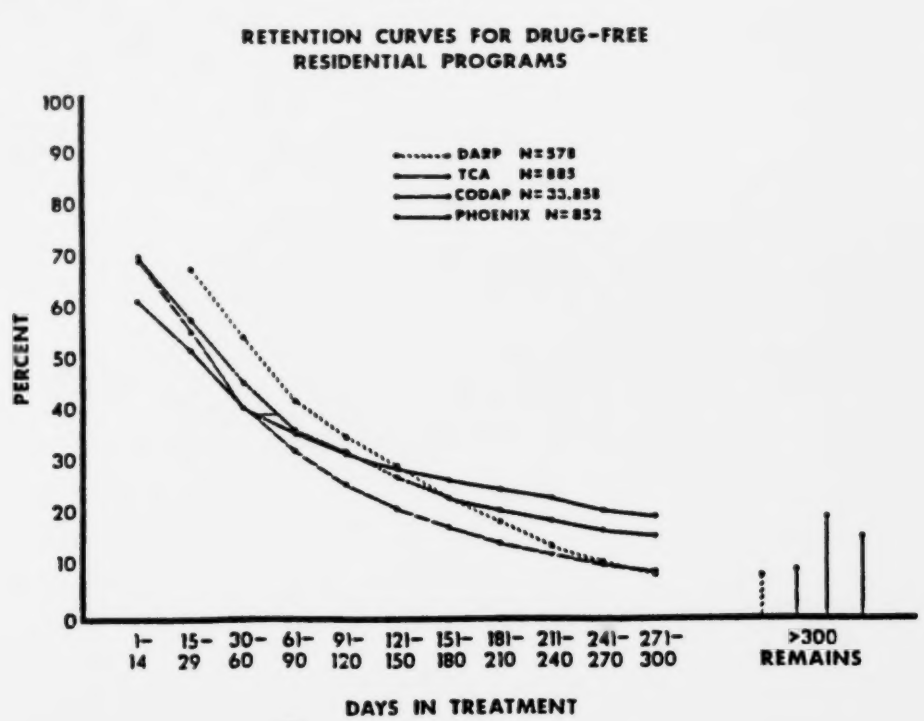

Success Group 4
1970-71 COHORT
3 CUM. YEARS POST-TREATMENT
1974 COHORT
3 CUM. YEARS POST-TREATMENT
PERCENT
100
80
60
40
20
0
Improvement
1970-71 Cohort
1974 Cohort
< 1
1-4
5-8
9-12
13-16
17+
Grad.
MONTHS IN PROGRAM


RETENTION CURVES FOR DRUG-FREE RESIDENTIAL PROGRAMS
DARP N=578
TCA N=883
CODAP N=33,858
PHOENIX N=852
PERCENT
100
90
80
70
60
50
40
30
20
10
0
1-14
15-29
30-60
61-90
91-120
121-150
151-180
181-210
211-240
241-270
271-300
>300 REMAINS
DAYS IN TREATMENT

Several background correlates of positive outcomes on drug use, criminality or employment have been identified, e.g., lower lifetime criminality, higher pre-treatment educational level, opioid as a primary drug (e.g., De Leon, 1983; Simpson and Sells, 1982). Though significant, these associations were small when compared with the effects of time in program; nor are they strong predictors of successful status measured with a composite index.

Retention

Time in program is the most consistent predictor of successful outcome. This finding stresses the importance of understanding retention as a phenomenon in its own right. Thus far, however, research has not yielded clear answers to three main retention questions: What are the retention rates? Who are the dropouts? And, why do clients leave or remain in treatment?

No client profile has emerged which predicts length of stay in treatment. Research reveals only sporadic and weak correlates of dropout involving demographic, primary drug, background characteristics, pre-treatment status and psychological adjustment. Generally, however, social background (lifetime) characteristics have not predicted long term retention, with the exception of less severe criminality.

Client status in the months prior to treatment is more closely related to retention. For example, those under legal pressure or whose health or lifestyle appears to have worsened, reveal somewhat longer durations of stay in TCs (Condelli, 1983; De Leon, 1983,; Holland, 1982).

Similarly, psychological profiles on entry into treatment fail to predict overall retention in treatment, although psychological factors still appear to be important. For example, several investigations indicate that early dropouts reveal higher levels of psychological dysfunction measured with standard paper and pencil instruments (De Leon et al., 1973; Sacks and Levy, 1979; Wexler and De Leon, 1977; Zuckerman et a., 1975). Some studies suggest that clients who showed less defensiveness and less denial of problems remain longer in treatment (De Leon, 1983).

One impressive finding obtained in a recent investigation involving a consortium of therapeutic communities revealed a striking relationship between psychological change during treatment and overall retention. Individuals who psychologically improved within the first several months after admission showed a significantly greater likelihood of continuing their stay in treatment (De Leon, 1980a). This finding has obvious implications for clarifying the relationship between client progress and retention.

Retention rates in therapeutic communities have received some attention in the literature (e.g., Brook and Whitehead, 1980; De Leon and Schwartz, 1984; Glaser, 1974; Sansone, 1980). The pattern of retention in long term therapeutic communities is orderly and predictable. Dropout is highest within the first 15 days of admission and declines sharply thereafter such that the likelihood of dropout decreases with length of stay itself (Figure 2).

Why clients drop out of treatment is a question that has not been adequately investigated, although hypotheses concerning dropout have been offered mainly from clinical impressions (e.g., Baekland and Lundwall, 1975; De Leon, 1984b; De Leon and Rosenthal, 1979; Heit and Pompi, 1977; Sansone, 1980). In Phoenix House followup studies, analyses of clients' retrospective reasons for dropout distributed equally between those relating to program problems (e.g., conflict with staff, views of treatment) and those that were more personal (e.g., wanted to continue using drugs, wanted to work). Program versus personal reasons differed by length of stay, with significantly fewer personal reasons associated with retention over 12 months in treatment (De Leon, 1984c).

Studies involving other therapeutic communities highlight the importance of the client's perception of self, the environment and circumstance in relation to dropout. For example, clients who enter treatment under legal or family pressure remained longer only if they perceive those pressures as negative (Condelli, 1983).

Treatment Process

Treatment process has been the least investigated problem in drug abuse treatment research. Ironically, the first process studies in TCs appeared more than a decade ago but their importance receded in favor of the need to establish firm information concerning treatment effectiveness. The relatively few process studies in the literature may be classified into 3 categories, studies of treatment change, direct investigations of treatment elements and client attribution of treatment influences.

Psychological change . Studies have examined clients' psychological change during their stay in programs without assessment of treatment components. They are reviewed as process studies since many of the psychological scores measuring change reflected program goals, e.g., attitudes, ego strength, emotional control, responsibility, self esteem, etc. Together with behavioral changes in drug use and anti-social behavior, these psychological changes during residency have strengthened inferences concerning the specific influences of treatment elements.

The studies employed standardized psychological instruments but vary with respect to design, number of variables measured and the number of observations during treatment (e.g., Biase, 1981; Brook and Whitehead, 1980; De Leon, 1974, 1976, 1980a; De Leon, et al., 1971, 1973; Kennard and Wilson, 1979; Sacks and Levy, 1979; Zuckerman et al., 1975). However, results are quite uniform in showing: a) the profiles or pattern of psychological scores is similar across programs and even cultures. For example, prominent are The signs of character disorder, personality inadequacy, mood disorder, poor self esteem and dull-normal intellectual level; b) overall psychological status improves significantly during treatment across most measures but generally does not attain normative or healthy levels. Larger improvements occur in self esteem, ego strength, socialization and depression. Relatively smaller changes occur in the more enduring personality features, e.g., the character disorder elements. Thus, drug abusers in the TC are psychologically similar and show significant improvement in most psychological domains, although long standing character traits are more resistant to change; c) psychological improvement post treatment generally exceed the gains made during treatment.

Studies completed at Phoenix House specifically correlated behavioral indices of drug use and crime (success status) with psychological improvement during treatment and at followup. Clients with an unfavorable success index at followup showed little psychological change during treatment or at followup. In contrast, clients who obtained a favorable success index had revealed significant psychological improvement during treatment and cont inued psychological gains at followup. This important finding offers indirect but positive evidence for the influence of treatment factors in the change process.

Treatment Elements . Some studies have addressed the relationship between specific treatment elements and client change during residential treatment. For example, results show significant reductions in self rated emotionality (depression, hostility, anxiety) and in physiological "upset" (systolic blood pressure) immediately following participation in encounter therapy sessions when compared with baseline measures (Biase and De Leon, 1969, De Leon and Biase, 1975).

Research at Daytop Village therapeutic community has çexperimentally evaluated the effects of a specific educational intervention (college credit courses) upon clients in a therapeutic community. Findings support TC assumptions concerning treatment process and role changes. The students revealed significantly enhanced self esteem over that expected from treatment effects alone in the TC (Biase, 1981).

Treatment process has been indirectly examined in studies of client perception of the therapeutic community environment (e.g., Bell, 1983; De Leon et al., 1980). Although preliminary, the results obtained across several programs are stable and orderly. All TC programs revealed a characteristic environmental profile that differed from hospitals and jails; and client perceptions of the environment were consistent with expectation concerning treatment change and length of stay. These findings support assumptions that traditional TCs are similar in philosophy, structure and practices.

Attribution. These studies have investigated client perceptions of their experiences in TCs. Generally, on measures of satisfaction, clients report a favorable experience in the therapeutic community and would recommend their particular residential program to others (e.g., De Leon, 1984c; Simpson and Lloyd, 1979; Winick, 1980). For example, successful followup status and length of stay in treatment significantly relate to satisfaction with treatment, the relevance of specific program components to followup status and client weighting of the relative importance of treatment and non-treatment influences upon their lifestyles since leaving treatment (De Leon, 1984c). Although clear, these findings must be cautiously interpreted, given their retrospective nature. Possible halo effects or dissonance factors might have influenced client perception of treatment experience and their own followup status. Nevertheless, the results firmly support hypotheses concerning the relationships between treatment experience, treatment elements and outcome status.

Summary

There are several conclusions from the review of the literature. First, a substantial number of admissions to TCs reveal favorable or improved behavioral and psychological status at followup. Notably, the percentage of positive outcomes increases directly with time spent in treatment. Research has yet to describe a client profile that predicts successful outcome, and only a few variables are consistent predictors of outcome other than length of stay. Second, dropout is the rule across TCs (and other drug treatment modalities) and

the temporal pattern of dropout is predictable; most admissions leave treatment before maximally beneficial effects are rendered. However, relatively little is known about who drops out or remains in TCs. Typical client profiles in relation to retention have not been delineated, and there are no variable that are consistent or large predictors of dropout. Research has not clarified the reasons for dropout, although studies point to the importance of the client's perception of the treatment environment and of their problems in influencing retention. Third, there is relatively little research on treatment process in TCs. The findings obtained support inferences concerning the process of change but the process itself remains to be investigated.

Some Implications for Research and Treatment

Perspective on Treatment Effectiveness. TCs are effective when evaluated in terms of their principle aim of modifying both social and psychological adjustment. However, this conclusion remains tentative in light of familiar methodological considerations, the most serious of which is the lack of control groups. The followup samples studied may be self selected to seek, remain in and benefit from the TC; or, perhaps to improve without any treatment. Thus far, however, solutions to these selection problems have eluded research strategies. There are ethical problems in withholding treatment; and assembling matched controls or comparative treatment groups through random assignment has not been feasible.

The methodological difficulties stress the need for a revised perspective on the interpretation of treatment outcome research which would reflect the multivariate complexity of individual change. One such perspective has been outlined for therapeutic communities in other writings (De Leon, 1980b, 1984a; De Leon et al., 1982). Briefly, successful outcome emerges from an interaction of client, treatment and non-treatment influence. The specific impact of the treatment experience is most apparent during and immediately following residency; thereafter, though less recognizable, treatment effects may integrate with (or perhaps alter) the contribution of later experiences in maintaining successful status.

This perspective emphasizes several assumptions that are also relevant for the design and interpretation of outcome studies. First, the drug abusers can be classified according to differences actually observed in relation to their treatment involvement. This suggests that the universe of drug abusers can be quadrasected, by definition; those who come to treatment and those who do not, and within each, çthose who make positive changes and those who do not. The natural history or treatment outcomes for these groups reflects their unique composition. For example, those untreated drug abusers who mature out of their addiction life-style are simple different people from those who enter treatment and change. This assumption then, avoids the dead end criticism of the no-treatment control since the four groups do not serve as controls for each other.

Treatment effectiveness should be assessed for those clients who seek or perhaps remain in treatment settings. Comparisons involving the clients in the three other groups, however, could reveal much about individual differences and the many influences that contribute to the change process.

Second, client change reflects an interaction between the individual and treatment. This implies mutual, bi-directional influences between the person and the treatment environment. Thus, treatment influences as unique measurable events are not readily extractable. Furthermore, the global treatment experience itself is an episode, one of many experiences in the individual's continually changing status. Thus, "proving" a treatment influence is less relevant than identifying its particular contribution to a continuing process of individual change.

Third, the primary source of information about this process is the client's own view of the relevant influences. External corroboration of client change through records or other testimony validates the fact of change, but does not reveal the reason for change. In the last analysis, it is the client who weights the relevant influences in his or her life.

A perspective on Retention. Dropout is a persistent but perhaps ç the least understood problem in substance abuse treatment. For therapeutic communities in particular, the importance of retention is illustrated in the fact that research has established a firm relationship between retention and outcome. However, most admissions to therapeutic community programs leave residency, many before treatment influences are presumed to be effectively rendered.

Within the context of the research reviewed, a perspective on retention can be drawn which guides the interpretations of dropout and hypotheses for further research. The drug users who seek treatment, particularly to one modality, are more similar than different. Thus, it is not surprising that research on their social and psychological characteristics reveals relatively low variability, and hence, little power to predict success or retention.

Nevertheless, those who seek treatment could be diverse in ways that have not yet been fully explored. These presumed differences reflect not who clients are, in terms of fixed background characteristics, but how they perceive themselves, their circumstances and their life options at the time of treatment contact. Assessment of these differences would focus upon at least four domains of client variables which alone or in combination affect dropout:

1) Circumstances (extrinsic pressures): These refer to external influences to seek and remain in treatment exerted by family, personal relationships, health and legal conditions, employment, educational and fiscal matters;

2) Motivation (intrinsic pressures): This refers to the severity of the problem (felt dissatisfaction, fear, pain) and the expressed need for personal change;

3) Readiness: This refers to the perceived need among motivated individuals to elect treatment to assist in personal change compared with non-treatment options, e.g., self-change or religious offerings;

4) Suitability: This refers to the client's appropriateness for, understanding and acceptance of a particular treatment approach.

Treatment Process . The TC cannot improve what it does without clarification of its process. Studies must render explicit the correlation between actual events in treatment and change in client status. It is this interplay between treatment elements and client change which defines process.

The first step in illuminating treatment process is a codification of the TC's perspective, basic elements, assumptions and practices. Several workers have undertaken efforts in this area (e.g., De Leon, G., 1981; Sugarman, B. 1981).

A next step involves development of program based research capability. Since treatment process research imposes heavy strains on program activities, it is understandably resisted by staff and administration. Thus, acceptance of process studies is facilitated by research teams who know the TC, can integrate with its staff, and can serve in educative roles (De Leon, 1979).

Alternatives to Long Term Treatment. Traditional TCs are highly effective for a certain segments of the drug abuse population. However, those who seek assistance in TC settings represent a broad spectrum of clients, most of whom may not be suitable for long term residential stay, as is evident in the high early dropout rates.

The issue of client diversity underscore the necessity for TCs to develop alternatives to long term residence and skilled diagnostic assessment capability. These, however, appear to counter the traditional TCs open door policy for admissions. Nevertheless, wise assessment of individual differences can only enhance the therapeutic community's capability for retaining those suitable for residential treatment and for offering appropriate options to others who do not enter or stay in long term treatment. Some TCs have acquired a diagnostic capability, although explicit clinical criteria and appropriate instruments for assessment of client differences remain to be developed.

TCs can offer service alternatives other than long term residence or referral to other modalities. For example, its method can be modified for both outpatient and short term residential models. There is an underlying concern that modification could dilute the unique strength of the TC approach itself. Can the traditional TC engineer its social and psychological effects without the 24-hour influence of the residential setting; or can it maintain the integrity of its community dynamic under a short term residential regime? These questions remain to be empirically answered. However, the issue of individual differences for the TC need not be one of changing itself, but adapting what it knows and does for the changing client. It is not whether long term residential treatment is appropriate for all clients; it is clearly not. The task, then, is to develop new ways of delivering the basic TC message and new tactics to produce its unique therapeutic impact.

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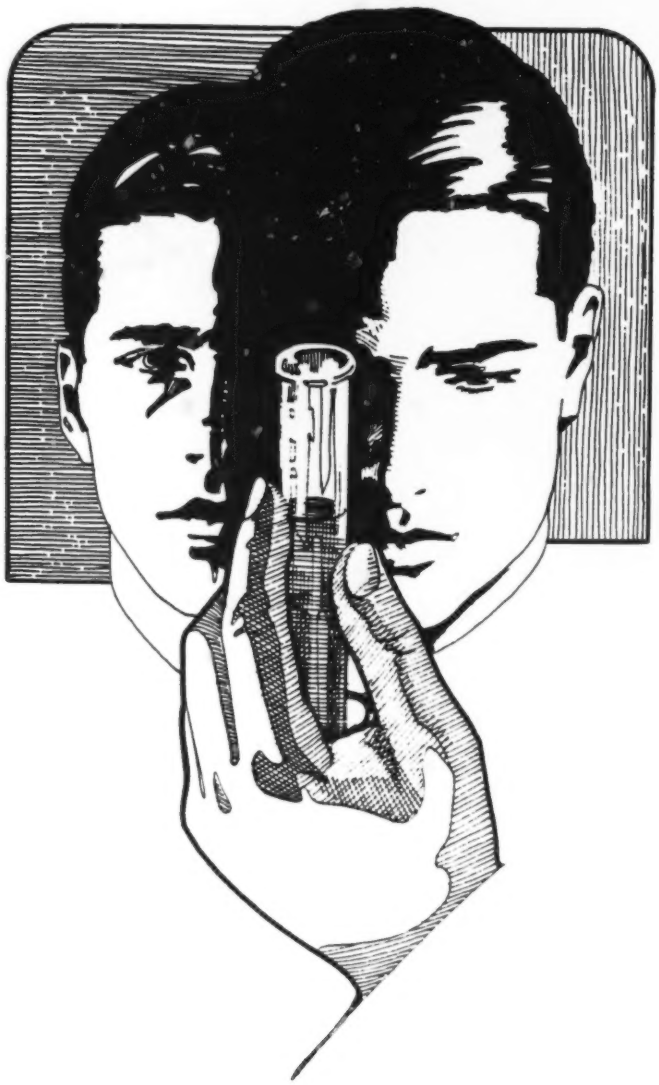

EMERGING CROSS-CULTURAL TC RESEARCH

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The authors wish to acknowledge the participation of the Daytop and Ce.I.S.T.C. residents and the collaboration of Letizia Pappalardo and Anna Maria Bianchi.

The last decade has seen a strong and consistent growing interest in the Therapeutic Community (TC) movement. This interest has been most prominent in the international community. Nations outside of the United States have recognized that the TC offers an effective drug free response to the treatment and rehabilitative needs of addicts and substance abusers. It offers an approach that is committed to responding to the psycho-social complexities of drug addiction and abuse.

The rapid growth in membership of the World Federation of Therapeutic Communities (WFTC) is just one reflection of this interest. Another aspect is the increasing involvement which Daytop Village has had in providing TC technical assistance to programs in foriegn countries. Daytop has developed the capability to strategically assist new TC programs in a number of countries including Italy, Sweden, Ireland, Canada, Norway, Brazil and the Phillipines. While TC programs in each of these nations are independent, Daytop, when requested, has dispatched staff to initiate new programs; provide for administrative development and support and assist in introducing the TC concept to foreign policy makers to help foster program understanding and acceptance. Each of these programs has progressed within its own cultural context and each has adapted and modified the TC philosophy. These modifications have shown us that the TC philosophy can generate effective treatment variants when adapted by creative TC colleagues while maintaining program integrity. It is this successful establishment of international TC programs that has fostered an increased interest in the area of research.

My comments today are intended to share with you information about the first TC cross-cultural research study which we've initiated between Daytop Village (New York, U.S.) and Ce.I.S. (Rome, Italy). The research emerges from an atmosphere which is committed to the development of the TC across international borders. Such a project could only have been undertaken where receptive, supportive and qualified collaboration existed. While teaching and training staff from Ce.I.S. in 1984, I was gratified by the degree of interest and enthusiasm shown toward the TC research program conducted at Daytop. It was soon apparent that these findings, which developed over the last six years in the Daytop Miniversity Project, had conceptual and clinical value to the Ce.I.S. staff. The scope of these findings provide the basis for this cross-cultural research project.

In the broadest sense, the research explores the psychological and self concept development which is part of successful TC treatment for addiction. We expect that the research findings will help to

- empirically define and describe international TC programs and residents;

- assess the different forms of TC treatment i.e. ambulatory, residential, short and long term;

- enhance TC programming by developing common methods of measurement;

- empirically support the development of TC treatment internationally.

To accomplish this TC cross-cultural research the following conditions existed between the Daytop and Ce.I.S. programs:

Concept Equivalence - A mutual agreement and consensus about the area of study; self concept and psychological development of residents. The equivalence was enhanced by on-site training and staff development.

Program Goals. The treatment approach of both programs, Daytop and Ce.I.S., are comparable and adhere to a TC drug free philosophy.

Behavior Goals. Both TC programs are based on a process of socialization, behavior change and personality development.

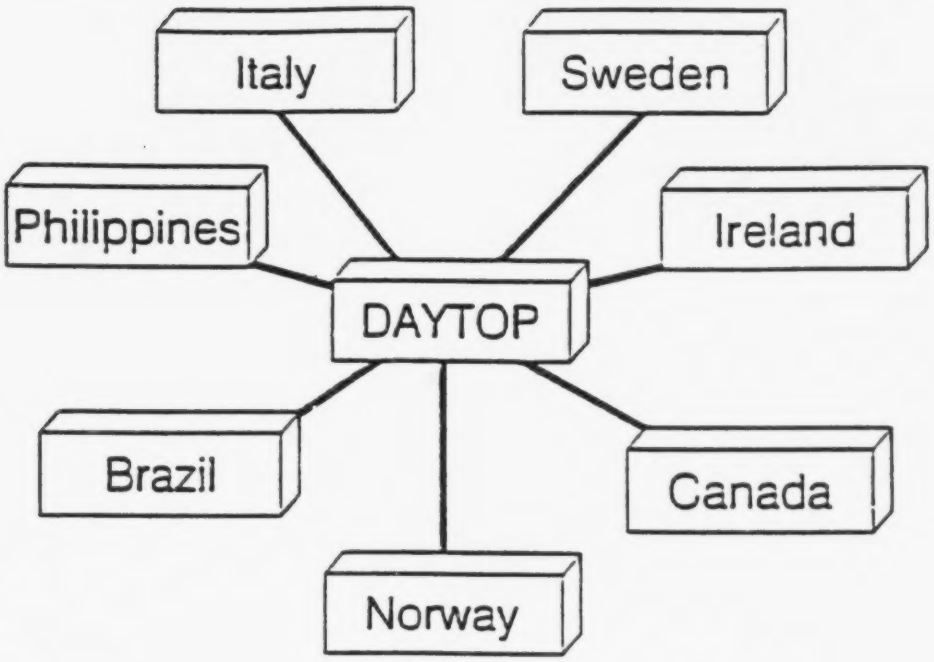

Exhibit 1

T.C. Cross-Cultural Comparability

- Concept Equivalence (Self Concept)
- Program Goals (Drug Free)
- Behavior Goals (Socialization/Personal. Dev.)
- Treatment Approaches (Encounter; Peer Self-Help) (Heirarchy; Re-Entry)
- Resident Profile (Age, Sex, Drug Abuse)
- Linguistic Equivalence (Accurate Translation of Self Concept Scales)

Exhibit 2

Treatment Approaches. Both programs rely on the encounter, peer self-help, a hierarchical social TC structure and a defined re-entry process.

Resident Profile. Both programs have comparable resident populations with regard to age, gender, marital status, drug abuse histories and type of anti-social behavior.

Linguistic Equivalence. A cross-cultural study requires that the testing instrument be translated accurately. The instrument was refined after two separate translations and a pilot test period. Translations involved a collaborative effort with individuals who were bilingual and worked within the TC setting.

After having insured that the above conditions were met, the first phase of the research work was successfully deployed. Data collection focused on three treatment environments of the Ce.I.S. This included the entry (Accoglienza) group - they had completed an average of 3 months in ambulatory treatment; the long term re-entry group - they had completed an average of 18 months of residential TC treatment; and the short-term residential group - they had completed an average of 6 months of residential TC treatment. I will briefly report some of the initial Ce.I.S. findings for the Entry and Long Term Re-Entry group. Analysis are being currently conducted, but as a result of the initial outcomes a model for cross-cultural TC research is developing successfully. Such a model will benefit international TC research, program evaluation and development. I wish to emphasize that we have found self concept and psychological assessment measurement to be adaptable in the Ce.I.S. treatment settings. Future reports will emphasize their use in international corss-program comparisons.

Presently we note that in this phase of the Ce.I.S. study the Entry and Re-Entry groups included 30 residents in each, with an average age of 23 years and 24 years respectively. The gender distribution was 80% male and 20% female in both groups. The primary drug for both groups was heroin with a low incicdence of poly drug abuse.

Profile and statistical analyses demonstrated patterns found in previous Daytop self concept TC research. The scores of the Entry group reflect a characteristically disturbed level profile and poor self concept scores, particularly in the areas of moral-ethical self and family self. These scores are accompanied by deviant self assessment scores in the areas of general maladjustment and personality disorder. The pattern as reflected in a composite score is similar to that classified as a personality disorder or emotionally unstable personality.

These Entry group residents responded to a daily regime of TC based ambulatory care combined with a program of family education and therapy. Despite their self concept patterns and addiction histories, more than 85% remained with the program, were drug free and progressed from ambulatory to residential TC when followed up one year later. This ambulatory Entry (Accoglienza) program is one unique example of the successful adaptation of the TC concept which was designed effectively for the Italian cultural and social setting.

When we analyzed the results of the scores of the Re-Entry group, we found evidence to support gains made within U.S. residential TC treatment. The Re-Entry group had participated an average of 18 months in residential TC treatment and an additional prior 6 months in the ambulatory TC program. Because the Entry and Re-Entry groups shared equivalent characteristics, we conducted a comparative analysis. Results showed significantly higher positive scores in all areas of self concept and improved psychological status scores.

There were also significant reductions in the general maladjustment and personality disorder scores. We are in the process of following up both groups for a second assessment in order to study their within treatment and post TC treatment status. Initial comparisons with Daytop U.S. data suggest directions for further exploration. The data indicate that the Italian Ce.I.S. residents report less deviant levels of self criticism and less psychological defensiveness at both the early and latter stages of treatment. This is corroborated by observations of staff and of the clinical interventions and strategies used. Also, despite presumed stereotypes of increased Italian family involvement, we have found an equivalent level of positive development of the family self by both Daytop and Italian residents who participate in long term TC treatment.

These early outcomes offer strong encouragement for future collaboration and build from the TC research base which has been developing over the last two decades. Research of this type will offer a basis for increased understanding of the process of successful TC treatment in different countries and cultures. It will provide empirically based information which W.F.T.C. members can share with helath workers and policy makers in their own nations, pointing to the effectivenss of TC treatment in the face of a worldwide increase in drug addiction and substance abuse.

Last year at the W.F.T.C. conference in Rome, we first introduced the concept of this Project. We look forward to our meeting next year in Eskilstuna to report on how these research activities are progressing with growth of the international TC movement.

	Daytop	Ce.I.S.
Age	26 yrs. (17-43)	24Yrs. (17-29)
Gender	75%m 25%f	75%m 25%f
Race/Ethnicity	Mixed	Same
Primary Drug	Heroin 59%/Polydrug	Heroin 100%
Time in Program	3/18 mos.	3/24 mos.

Exhibit 3

Features

- Successful Cross-Cultural Self Concept Research
- Comparable Treatment Program and Residents
- Empirical Support of Int'l. T.C. Treatment
- Unique Cultural Differences
- Design for Future Int'l. T.C. Clinical Research

Exhibit 4

FOLLOW-UP OF FORMER RESIDENTS OF THE EMILIEHOEVE, A TC FOR DRUG ADDICTS

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INTRODUCTION

A question that most visitors of the Emiliehoeve, the first T.C. for addicts founded in the Netherlands, asked is: What is the effect of this intensive treatment program? It was also the question I had a few years after I founded, in 1972, this Community in a deserted old farm on the premises of a psychiatric hospital in the Hague.

A follow-up research project was developed at the Department of Preventive and Social Psychiatry of the Erasmus University in Rotterdam where I, at that time, was and still am teaching medical students.

Before I shall present some of the preliminary results, I shall give some information on the development of the Emiliehoeve program and some background information of the residents treated.

The Emiliehoeve program was started as an alternative for existing treatment programs in the early 70's because they were not successful in stopping the addiction of their clients.

Drug addiction was a new phenomenon in Holland and the treatment consisted in those days of outpatient treatment at the clinics for alcohol, where the drug addicts were also referred, and admissions in psychiatric hospitals. In the outpatient clinics Methadone treatment was introduced in 1969. In fact, I was one of the first doctors in Holland prescribing it to opiate addicts. It took me two years to find out when I finally decided to apply urine tests, that all of my clients were either continuing to use their opiates or taking other drugs or pills.

In the psychiatric hospital where I worked, I discovered that the addicts did not change their behavior; they only learned to combine their drug abuse, that they continued after admission, even in closed wards, with the use of tranquilizers they had obtained from fellow patients.

A show performed in a theater in the Hague by re-entry residents of Daytop Village in New York on the history of a resident that came to this T.C. program made me aware of the existence of a different approach. This was the first occasion that I saw recovered addicts.

With a group of professionals, a psychologist, social workers, an artist, and myself, a psychiatrist, we started a T.C. with little or no experience in the treatment of addicts and none with TCs.

The residents were regarded as sufficiently grown-up to be involved and trusted to make decisions in a one man-one vote way.

There was no clear structure in the program, little or no limits were set to the residents behavior and the therapy groups, run along psycho-analytic lines, focused on the past rather than on the here and now. Although no methadone was given, tranquilizers and sleeping pills were administered during the first few weeks of admission.

The program during those first months can be characterized as extremely chaotic, the most negative students served as role models and the residents did not change addictive behavior.

After the therapeutic staff had attended a marathon encounter group run by a former director of a Phoenix House in New York, and later the first director of Phoenix House, in London, the program underwent drastic changes. It became clearly drug-free from the day of admission, and, most important, encounter groups were started in which behavior was confronted and the residents learned to express their emotions in a direct way.

This was five months after the start of the program and the program went into its second phase. The population grew in the course of the following years form the original ten residents to forty.

Step by step, further elements in the program: a hierarchical resident structure, verbal reprimands called "hair-cuts", learning experiences and different levels in the treatment program (introduction, new residents, middle group, older residents, re-entry from a separate house in the city) were introduced following the model and concept of the TCs in America. the staff was supported in this by visiting ex-addicts who had been staff in America and British TCs who were employed as consultants. After the radical change the results obviously improved. Ex-addicts who had graduated the program could be included in the staff. Whether the other added elements also increased the positive outcome had to be found out through follow-up results of the research that was started in 1974.

RESEARCH BACKGROUND

The first 240 residents were admitted during a five year program after its foundation in 1972. Readmissions within one-half year after departure were regarded as being the same admissions. Readmissions after having been out of the program for more than one-half year are excluded in this report.

Of the readmissions in 1972 through 1974, 71 percent of the residents had no other than primary education. During the following years the education level went up. (Only primary education levels in 1984 was 34 percent.) During the course of the years, fewer residents came from lower social class background (estimated) from 37 percent in 1972-74 to only 9 percent in 1983.

The mean age of 20.6 in 1972-74 raised to 21.1 in 1976 and 24.4 in 1983.

There had been no change in referrals from courts (9-10 percent); 53 percent of all residents had been in prison before admission.

Over the years the male-female ratio has been 7:3. During the years 1972-76 there were no residents from minority groups. In 1982 there were 17 percent minorities, mostly from Surinam.

The abuse of different drugs was in 1972-74 an average total of 2.87; in 1976: 3.77. In 1983 it was 3.97. Over the years there has been a considerable change in the drug use patterns apart from the trend to use more different drugs.

In 1972 the drugs of preference were amphetamines, while in 1983 they were clearly replaced by opiates as the most popular drugs. From 1976 methadone became more easily available. In the same period the duration of the addiction before admission increased from 3 to 7 years.

THE FOLLOW-UP RESEARCH

The first 240 residents were seen in a face to face interview usually at the place were they were living by students who worked yearly during five months in the project as part of their study; each year different students, two to five in number. To get acquainted with the program they lived for two weeks in the Emiliehoeve T.C. before they started to visit ex-residents. A group of 60 residents of a T.C. in Rotterdam, Essenlaan, admitted in a period when this community had a similar concept and structure as the Emiliehoeve, was visited as well.

Also, a group of 60 people was interviewed that visited the induction center, was accepted but dropped out before admission. All ex-residents were visited at least half a year after they had left the program. They were reinterviewed a maximum of three times in a maximum period of five years, unless they had clearly relapsed in their addictive behavior.

Although many successful ex-residents were followed-up in one or more further interviews it was decided to choose a two year period after discharge to consider outcome results.

The main reason was that 80 percent of the first 240 residents of the Emiliehoeve program had been interviewed after they had stayed at least two years out of the program, while the percentage seen three or more years after discharge was considerably less.

Another reason is that research so far showed that almost all relapses already occurred within one year after clients had left a program and that more factors unrelated to the treatment in the T.C. were affecting the outcome results when more time had elapsed after they left.

The program was divided into subsequent phases. The first one has been described above as the loosely structured program before confrontation of the current behavior had began in encounter groups. During the

following phases other elements apart from the encounter groups, the setting of clear limits, and the drug-free philosophy were added.

The results were allocated to the phase during which they were admitted. Those admitted during the last four months of a phase were excluded when the phases were compared as they may have stayed for a considerable time in treatment during a following phase.

As the goal of the program was complete abstinence from hard drugs, absence of any addictive behavior, criminal acts and serious psychiatric disturbances rather rigid criteria for success were chosen:

Ex-residents should have during the first two years after the program: no use of any hard drugs at any time, no use of cannabis, tranquilizers or sleeping pills for more than two consecutive days. (No regular or daily use in an addicted way.) No arrests, no admission to psychiatric hospital and, no treatment for addiction.

As a period of less than two weeks spent in the program was considered insufficient to expect any change, those clients (30 out of 240) were excluded and will be considered as a separate group. Follow-up results of this group and the intake-only group (clients that dropped out before admission) as well as of the Essenlaan T.C. will be reported of later.

Of the 240 residents, 141 follow-up evaluations could be used. Out of a total of 240 admissions, there were 5 records incomplete at admission, 36 spent less than 14 days in the program, 9 had to be excluded as the main reason for admission had been psychiatric disorder rather than addiction, and 49 could not be traced or refused the follow-up interview. This left 141 subjects in the follow-up study.

Results of residents allocated to different phases in the program were compared. Also outcome was compared with time spent in the program. Followup results of a cohort of residents present on one day were compared.

RESULTS

The success percentages following the abovementioned criteria of two years "clean" after discharge (residents staying in the program less than 14 days were excluded) are:

	N=48	N=37	N=56	N=141
Time in program	14 days - 4 months	4 months - 1 year	more than 1 year	Total
2 years clean	21%	16%	59%	35%

Of the total of 141, 33 percent of the males were successes and 39 percent of the females. However, among residents staying more than one year there was no sex difference. The difference appeared to be related to the finding of more early drop-outs among males.

There is a significant difference in success between the groups up to one year combined (19 percent success) and the group who stayed in treatment for more than one year (59 percent). There is no significant difference between the groups that stayed less than a year.

There was no significant difference between residents leaving before graduation who stayed longer than one year in program and residents who graduated.

There was no significant difference in outcome results using the sharp criteria between the residents of the different phases in the development of the treatment program apart from phases one, where none of the residents became successes.

There was also a clear difference in the percentage of early drop-outs, residents staying less than 14 days, between the first (33%) and the latter phases (14%).

For the total this percentage was 15 percent (36 of the 240 residents).

Of all 240 residents 28 percent stayed longer than one year in the program.

Of those residents who stayed at least two weeks 34 percent stayed longer than one year (36% when residents of phase one are excluded).

Compared with the findings of De Leon (1984), from seven TCs combined, we see the following:

	De Leon	Emiliehoeve
2 weeks	70%	85%
4 months	32%	48%
10 months	15%	32%

To conclude I shall briefly mention the following finding to be published elsewhere. Twenty-three residents staying in the community on one randomly chosen day were compared on the following results. Twelve had graduated from the program, eleven had dropped out before graduation, eleven of the twelve graduates were successes on the above described sharp criteria and only one of the eleven dropouts. Of the total population 50 percent were successes when seen at follow-up interviews at least one year after they had left the program.

DISCUSSION AND CONCLUSION

Follow-up research is not only difficult to carry out, it is also difficult to interpret. When we use the here described sharp success criteria it must be understood that the residents not falling in this group are not all total failures. Many of them had only a short relapse and are doing now quite well. Some only used once and decided that it was not what they had expected. Some work as respected staff members in the treatment programs.

There are other methodological problems to be faced. If all residents in a study are included also residents that stayed only for a day, you are not measuring the intended treatment. If you only consider graduates you look only at a small group of the total of clients admitted (for Emiliehoeve - 22 percent).

There was no difference in outcome found between the phases, except between phase one and the others. This is in line with findings of the DARP follow-up study.

More refined research is needed to arrive to definitive conclusions whether quality of the program is a factor in determining success.

Success improved considerably, however, as residents stayed in the program longer than one year.

It is clear that a drug-free philosophy, encounter groups, and clear limit setting to destructive behavior were important to reach any good results in the Emiliehoeve program.

In further analysis only the residents admitted after phase one are analyzed in the follow-up to be compared with the pre-treatment situation recorded in the admission forms and with the results of the intake only, the less than fourteen day admissions and the Essenlaan T.C. group.

LASTING EFFECTS: DETOXIFICATION FROM METHADONE MAINTENANCE IN A TC

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Therapeutic communities and methadone maintenance programs view the use of medication in different ways. David Deitch (1973) has pointed out that until recently there existed a basic animosity between these two treatments, even though together they account for 43% of the people in drug treatment in the United States (Vischi, Jones, Shank, and Lima; 1980). Therapeutic communities grew out of a self-help model that viewed drug dependence as undesirable, even when the drug was a medication prescribed by a treatment program. Professionally dominated methadone maintenance programs, on the other hand, viewed the medication-free stance of the therapeutic community as closed-minded and unrealistic. Cooperation has developed slowly, as therapeutic communities have begun to recognize the uses of medication, and graduates of therapeutic communities broke down staff prejudice by working in maintenance programs. In the methadone program at which this project was based, for example, three of seven clinic counselors gained their drug treatment experience in the therapeutic community movement.

Not until 1979 did the first report appear on the role of a therapeutic community as a way for maintenance clients to achieve detoxification (Kaufman, 1979). Kaufman documented the detoxification of 94 to 215 admissions (44%) at the Su Casa therapeutic community. Although Kaufman presented little follow-up information, methadone detoxification in a therapeutic community clearly shows promise as one of several areas in which these two treatments can collaborate (Sorensen, Deitch, and Acampora, 1984). Marsha Rosenbaum has called methadone detoxification an "arduous task", which is made more difficult by the presence of models of failure in the methadone clinic (Rosenbaum and Murphy, 1984). Kuncel (1981) has reported that more intensive counseling in maintenance can be associated with lowering of methadone dosage, and the need for post-detoxification milieu support is clear (Milkman, Metcalf, and Reed, 1980); presumably the intense treatment offered in a therapeutic community could help methadone patients to detoxify and remain abstinent.

At the 1981 World Conference Acampora and Nebelkopf presented an approach used by Walden House that enabled people on methadone maintenance to detoxify in a therapeutic community (Acampora and Nebelkopf, 1983). At the 1983 World Conference our group presented preliminary results for 28 people who entered Walden House with the goal of detoxifying, indicating that 46% achieved detoxification and, upon terminating from the research project, were improved in several areas of functioning (Sorensen, Acampora, and Deitch, 1984). A subsequent publication documented the clinical methods that were used, including the preparation necessary for maintenance clients to enter a therapeutic community, the treatment regime, and the collaboration needed between the therapeutic community and the methadone maintenance clinic to bring about successful treatment (Sorensen, Acampora, and Iscoff, 1984, reprinted in this volume).

Evaluations of effectiveness in therapeutic communities have been hampered by the use multiple indicators of success, for example, decreased criminal activity, less drug abuse, and more employment. George De Leon has pointed out that these multiple measures of outcome tend to obscure the association between treatment and the person (De Leon, Wexler, and Jainchill, 1982). For example, they may show changes across clients, but they can mask the changes that individuals make while in treatment. Further, the use of multiple measures in a study takes advantage of chance associations.

These issues molded the follow-up study that we are reporting here. We summarize follow-up results with the entire sample of 32 clients who entered the maintenance to abstinence project of Walden House. To our knowledge this is the first report of follow-up information on clients who entered a therapeutic community to taper from methadone maintenance, and it uses composite measures as the key indicator of outcome.

METHOD

The Sample

Background and treatment characteristics of the first 28 subjects have been reported previously (Sorensen, Acampora, and Deitch, 1984); characteristics for the complete sample of 32 subjects appear in Tables 1 and 2. The group that entered Walden House was predominantly male (81%), White (69%), and on the average in their late twenties to early thirties. Nearly half were on probation or parole. Most had started using heroin in their late teens and had been using narcotics for an average of 13 years. They were admitted to the therapeutic community on a mean methadone dose of 37 mg and had been on methadone maintenance for an average of 27 months. About half (53%) were in their second, third, or fourth time on methadone maintenance, and about half (53%) had been in a therapeutic community before. In summary, this was a group with considerable treatment experience.

Table 1

Background of Subjects Entering the Therapeutic Community
N = 32

Sex (percent men)	81
Age in years (men)	33.0
20-29 (percent)	44
30-39 (percent)	50
40-49 (percent)	6
Ethnicity (percent)	
White	69
Black	13
Hispanic	6
Asian	9
American Indian	3
Employment (percent unemployed)	78
Education (percent high school graduate)	66
Marital status (percent married)	22
Oobation or parole (percent)	44
Court case pending (percent)	31
Age of first heroin use (mean years)	17.7
Years since first daily heroin use (mean)	12.7

Background of Subjects Entering the Therapeutic Community
N = 32

Living situation prior to therapeutic community (percent)	
Alone	22
With parent or relative	19
With spouse or lover	38
With roommate or friend	16
Jail or prison	3
Other	3

Table 2

Treatment Characteristics of Subjects Entering the Therapeutic Community
N = 32

Time on methadone (mean months)	26.8
Less than 1 year (percent)	40
1 to 3 years (percent)	43
3.1 to 6 years (percent)	10
6.1 to 11 years (percent)	7
Dosage at intake (mean milligrams)	36.5
1-30 mg (percent)	28
31-40 mg (percent)	44
41-60 mg (percent)	28
Prior therapeutic community treatment (percent)	53
Prior alcohol treatment (percent)	23
Prior methadone maintenance treatment (percent)	53
Prior drug treatment admissions (mean)	5.6

Techniques of Locating Subjects

Subjects were located primarily from information given to the project during their treatment. At study intake each subject was approached to give permission to be followed up; each was asked to provide the names, phone numbers, and addresses of at least two people who would always know where they were living, in addition to the address and phone number of the place where they anticipated living at follow-up. Periodically during treatment in the therapeutic community and at termination subjects were reminded of the research project's desire to locate them for follow-up, no matter how things were going, as a way to evaluate the effectiveness of this kind of treatment. We updated telephone numbers and addresses throughout the treatment process. At the time of follow-up these leads were followed first. If the project was unable to locate subjects through these methods, a paraprofessional staff member attempted to locate them through street contacts.

The Instruments

The follow-up protocol used a structured questionnaire that surveyed the life situation of the subjects since their previous interview. The survey contained 53 questions with multiple choice or scaled ratings that focused on seven general areas: (1) family life/living situation, (2) legal problems, (3) income/employment, (4)

social supports, (5) drug use, (6) treatment after termination, and (7) overall functioning. Following the interview the staff member made global ratings based on the information gathered in the follow-up interview and any information gathered in locating the subject. These ratings covered the most usual level of functioning for the subject in the months since the last interview. Ratings were made on a four-point scale from "poor functioning" (1) to "good or excellent functioning" (4) on six scales: Family life/living situation, living within the law, health, employment/education, substance abuse, and considering everything known. These global ratings were identical to rating items made at study entry and at termination from the research project. A final rater judgment of response accuracy indicated whether the information gathered in the interview was very reliable, acceptable, or of questionable reliability. If questionable, the rater indicated which items were in question and why. Questionable items were treated as missing data in the analysis.

At the end of the interview the subject was asked to provide a urine sample, which was collected under observed conditions. Samples were tested for nine drugs of abuse, using the thin-layer chromatography technique, by a laboratory licensed for such testing by the State of California.

Subjects reported alcohol intake by summarizing the number of cans of beer, ounces of wine, and ounces of liquor consumed in the last week. To arrive at an acceptable method of determining the amount of alcohol they drank, as opposed to alcoholic beverages of varying strengths, we devised an algorithm that calculated the amount of alcohol in each type of drink. This involved multiplying the number of beer cans drunk by .6 ounces, the number of ounces of wine by .12, and the number of ounces of liquor by .4. The total ounces of alcohol were then summarized for the week.

Creation of Composite Functioning Scores

The data analysis strategy was to investigate the use of interviewer summary ratings as a key indicator of functioning. To assess the accuracy of summary ratings, these were compared with subjects' responses to specific questions within the follow-up interview. Interviewer evaluation of clients' living situations correlated .58 with subjects' satisfaction with their living situations. Interviewer and subject ratings of legal problems corresponded closely ($t = -2.43$ pooled variance estimate, 4 df, $p < .05$,) as did their ratings of employment ($t = -5.26$ pooled variance estimate, 24 df, $p = .001$). Interviewer ratings of substance abuse corresponded closely with subjects' self-disclosure of their usage of heroin ($t = 2.16$ pooled variance estimate, 24 df, $p < .05$) and their alcohol intake ($t = 1.96$ pooled variance estimate, 24 df, $p = .06$). Interviewer ratings of substance abuse corresponded closely with the clients' report of using or not using drugs ($t = 3.52$ pooled variance estimate, 24 df, $p < .005$). Interviewer global ratings correlated .71 with subjects' global self ratings.

The pattern of intercorrelations suggested that these items were measuring related, but varying aspects of global functioning. The ten intercorrelations of subject ratings ranged from .10 to .69. The six interviewer summary ratings correlated more closely with each other (Pearson's r ranged from .56 through .88).

The high intercorrelation of the interviewer ratings, coupled with their acceptable correspondence to specific information provided by subjects, justified their choice as the source of a composite indicator of functioning. The six interviewer summary ratings were added together to create a composite functioning score. Correlations of the six summary ratings with the composite score ranged from .85 through .98.

RESULTS

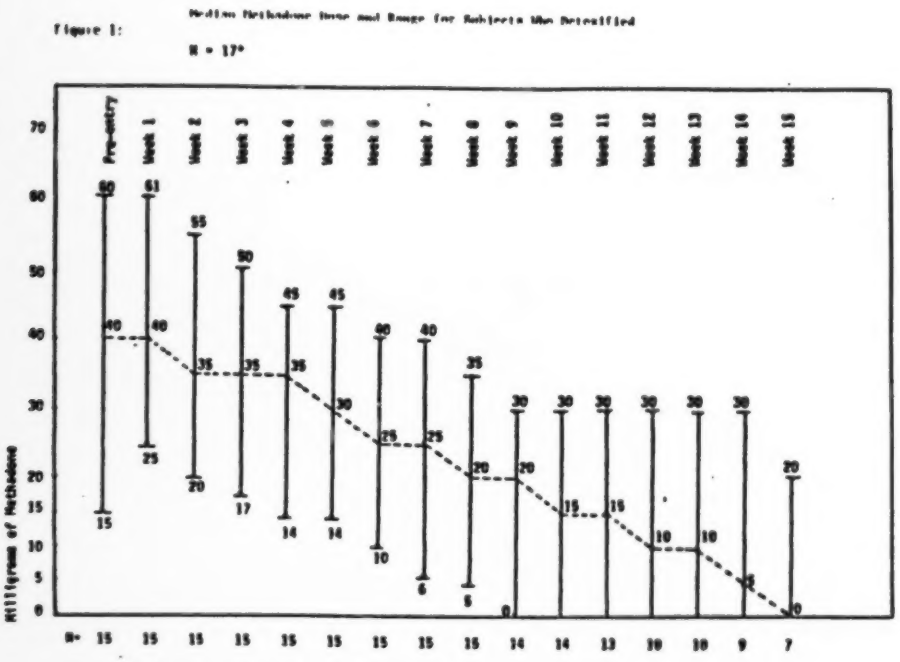
Achievement of Detoxification

As previously reported (Sorensen, Acampora, and Deitch, 1984), 13 of the first 28 subjects detoxified from methadone at Walden House; when the entire sample of 32 subjects was included, 17 (53%) detoxified. Figure 1 presents the median dosage for the subjects who detoxified from methadone in Walden House. Generally the subjects initially stabilized their dosage, then reduced their dosage gradually to 0 mgs. The most typical pattern was dose reduction of approximately 10 mgs per month.

Follow-up Outcomes

Of the 32 subjects, one had died before the time for follow-up, one withdrew his consent for follow-up, and one stayed only three days in the therapeutic community and was not approached for follow-up consent. Of these 29 subjects, 26 were reached for at least one follow-up interview (90%), and three could not be located. The original plan had been to conduct follow-up interviews three months, six months, and one year after termination. The project did not achieve this goal, with 14 interviews occurring 0-6 months after termination, 12 interviews 7-12 months after termination, and 13 interviews occurring 13-24 months after termination. Given the small numbers of subjects reached in each follow-up period, we used the last followup with each subject as the indicator of long-term outcome. These interviews ranged from 4-24 months

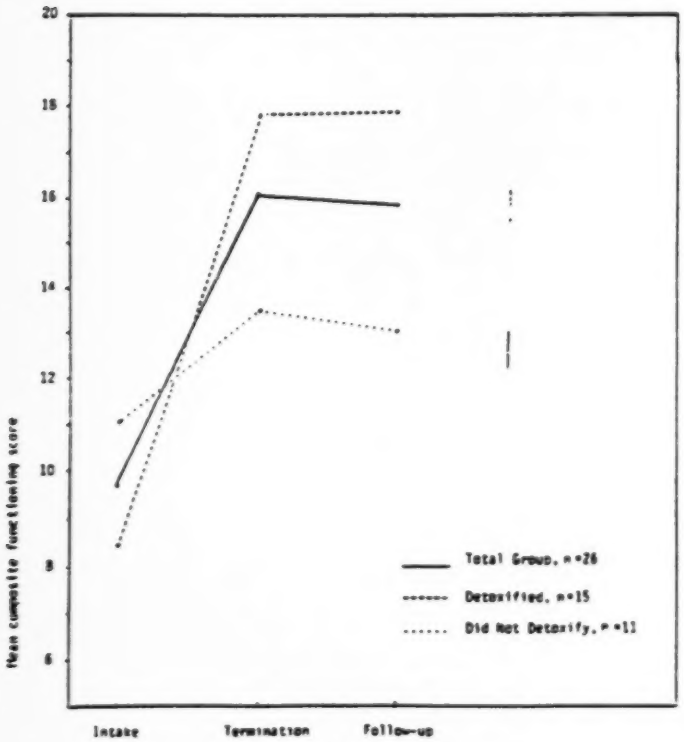
Figure 1:



*Dose records are unavailable for 2 of 17 subjects

Figure 2

Mean Composite Functioning Scores For Subjects



after termination, with a mean of 12.0 months and a median of 13.0 months after termination from the research project.

Living situation at followup.

When summarizing their living situation at followup, 19 subjects rated it as better than before entering Walden House, 3 as the same, and 4 as worse. Four of the 26 subjects were still living in the therapeutic community or its outpatient apartments. Three subjects admitted to living in a household with other adult addicts using heroin. Ten were either on probation or parole, as compared with seven at entry. At followup, three had legal cases pending, compared with seven at entry. Twelve subjects were either working or in a full-time educational program at followup, compared with seven at entry into the therapeutic community.

Seven admitted to abusing drugs of some kind (opiates, stimulants, depressants, etc.) at the time of followup, compared with 20 at entry into the therapeutic community. This included five who admitted continued opiate use at followup, compared with six at entry. Eleven admitted to use of alcohol at followup (range = 1-45 ounces per week, mean = 5.3 ounces), compared with 14 of the 26 at entry (range = 1-95 ounces per week, mean = 13.5 ounces).

Comparison of pre, termination, and follow-up functioning.

Composite functioning scores revealed significant differences between entry into the study and termination (mean pre score = 10.5, mean termination score = 16.1, $t = -5.03$, 23 df, $p < .001$) and between entry into the study and followup (mean follow-up score = 15.4, $t = -3.61$, 23 df, $p < .01$). The functioning of subjects at followup did not differ from functioning at termination ($t = 0.46$, 23 df, ns).

The components of the composite functioning score were examined to determine areas of change in subjects' functioning between study entry and followup. These analyses revealed significant improvement in subjects' family life/living situation ($t = -2.79$, 23 df, $p < .05$), employment/education ($t = -2.87$, 23 df, $p < .01$), substance abuse ($t = -4.65$, 23 df, $p < .001$), and overall functioning considering everything known ($t = -4.40$, 23 df, $p < .001$).

In an effort to determine whether poorly-functioning subjects dropped out of the followup early, the subjects were divided into two groups: Those subjects whose last followup occurred within one year of termination and those subjects whose last followup occurred after one year of termination. The groups did not differ on interviewer ratings of composite functioning.

Functioning of Subjects Who Completed Methadone Treatment Versus Those Who Did Not

Previously we reported staff's global ratings at termination, which revealed that those who completed detoxification were functioning significantly better than those who did not detoxify (Sorensen, Acampora, and Deitch, 1984). The follow-up results indicated that these differences endured. Figure 2 illustrates the relationship between the composite functioning of subjects who detoxified versus those who did not, at intake, termination and follow-up. The groups differed in change from intake to termination and in change from intake to follow-up; in both cases those who detoxified showed more positive change.

DISCUSSION

Overall, 53% of the subjects who entered the therapeutic community completed detoxification from methadone. The subject group showed improvement in functioning, as revealed in composite rater evaluations, especially those who detoxified from methadone. The gains lasted to the time of followup. These results are encouraging, in that they provide an example of successful collaboration of a therapeutic community with a methadone maintenance program. William Hargreaves (1983) has commented that "we still do not have the evidence that maintenance is a treatment that can increase the probability of eventual abstinence" (p. 69). Although the lack of comparison groups in the present study does not provide evidence to refute this claim, the present results indicate that the collaboration of therapeutic communities and maintenance programs may provide a way to improve the outcome of maintenance treatment for those clients who are willing to enter a therapeutic community.

The study is limited in several ways. First, this is only the second study of detoxification from maintenance in a therapeutic community, and the first to provide consistent followup information. The followups were relatively short, and varying in length of time since termination. Future investigations should should employ longer followup.

The current project, however, established that there can be a rich commerce of ideas and people between these two types of drug treatment programs. It led to our current attempt to use therapeutic community principles in an outpatient tapering and aftercare program, staffed principally by paraprofessionals who graduated from a therapeutic community. That study is currently underway.

In closing, it is important to point out that medications such as methadone may have their place in therapeutic community treatment. Lamberti and Blyth (unpublished data) point out that it is highly therapeutic to teach that the healthier family members in a therapeutic community can look out for and make concessions for the not-so-healthy. In this way the antisocial personality learns care, concern, and sensitivity, while the more fragile person benefits from the structured environment that is needed to stabilize. The inclusion of patients on methadone and other medications expands scope of the therapeutic community scope to encompass a new group of potential residents.

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CIRCUMSTANCES, MOTIVATION, READINESS & SUITABILITY: DO THESE FACTORS RELATE TO TREATMENT TENURE IN THERAPEUTIC COMMUNITIES?

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ABSTRACT

Research has convincingly demonstrated that successful outcomes in TCs are related to length of stay in treatment. However, little is known about the factors that predict which people will stay in treatment. Clinical experience suggests that the differences between those who drop out and those who remain in TCs are reflected in such factors as motivation or readiness for treatment.

A 52-item instrument was developed to measure circumstance (pressure), motivation, readiness and suitability for therapeutic community treatment. This instrument (the CMRS) is routinely completed in Phoenix House within 72 hours of admission. This paper reports preliminary findings on CMRS profiles obtained on all admissions to Phoenix House across a 4-month period. Results describe the differences in the CMRS by age, sex, race, primary drug of abuse and time in program. Findings indicate that motivation, pressure, readiness and suitability are predictive of retention in residential treatment. The CMRS appears to be a promising tool for assessing client differences, particularly for appropriate assignment to residential or non-residential treatment.

INTRODUCTION

The most consistent predictor of successful outcome in therapeutic communities has been length of stay in treatment. Nevertheless, most admissions to TCs leave before treatment benefits are evident.

Indeed, dropout is the rule across all drug treatment modalities. However, little is known about who the dropouts are, much less why they leave treatment. No client profile has emerged that correlates with length of stay in therapeutic communities. Moreover, studies fail to yield strong predictors of dropout in any treatment modality.

The fact that retention is difficult to predict from client characteristics suggests that the population studied (drug abusers seeking treatment) are, not unexpectedly, more similar than different. Hence, measures of their characteristics tend to show relatively low variability.

Nevertheless, even those who seek treatment could be diverse in ways that have not yet been fully explored. These presumed differences reflect not who clients are, in terms of fixed background characteristics, but how they perceive themselves, their circumstances, and their life options at the time of treatment involvement. Assessment of these differences could focus upon at least factors which alone, or in combination, affect dropout:

(1) CIRCUMSTANCES (extrinsic pressures): These refer to the external conditions that drive people into treatment but do not necessarily reflect inner reasons for changing oneself. External pressures may include: Losses (e.g., social-personal relationships, family support, job, school status, children, money, etc.); Fears (e.g., jail, injury, violence, health risks, suicide or death from overdose).

(2) MOTIVATION (intrinsic pressures): These refer to the individual's own inner reasons for personal change. Such reasons may be: Negative (e.g., their acceptance of drug use and other adjustment problems as serious; their experience of guilt, self-hatred or despair; their fatigue with drug use and drug related lifestyle); and/or, Positive (e.g., their wish to make a new lifestyle, their belief that they can be successful, and have the good things in life; their desire for personal growth, to be a better person, parent, spouse or mate, etc.)

(3) READINESS: This refers to the individual's perceived need for any treatment to assist in personal change, compared with alternative options. Individuals can be motivated to change but may not see the

necessity for treatment in the change process. They may favor non treatment alternatives such as: Self Change (e.g., directing themselves to be in control, manage their problems on their own); Other Options (e.g., help through friends, relationships, religion, employment, geographical relocation, etc.).

(4) SUITABILITY: This refers to the appropriate match between the individual and a particular treatment modality, such as the therapeutic community. An individual may be motivated and ready for treatment but may not be appropriate for the TC. Suitability is indicated by the individual's acceptance of the TC approach; its goals and philosophy (e.g. abstinence, socially productive lifestyle, self help and psychological growth); its regime (e.g. community living, lack of privacy, cardinal house rules, rational authority, few traditional professional staff, peer management); its, methods (e.g. resocialization, work therapy, full participation in groups and meetings, and willingness to interrupt life and relationships and make a long term commitment). Suitability is also evident in the individual's rejection of or exhaustion with other treatment options or modalities.

The relevance and clinical utility of these 4 factors are currently being investigated as part of ongoing research at Phoenix House on the problem of retention. The focus of this work is upon short term (30 days) retention since this is the period of highest attrition in all drug treatment modalities. For TCs in particular, approximately half of all dropouts leave within the first 30 days of admission (see figure 1). The present paper reports preliminary findings on the relationship of the 4 CMRS factors to short and longer term retention.

PROCEDURE

A fifty-two item instrument was developed to measure circumstance, motivation, readiness and suitability for therapeutic community treatment (The CMRS). The items were provided by clinical staff who as recovered substance abusers were asked to write down their memory of the factors associated with their entering or remaining in treatment; and by new admissions and senior residents in treatment whose word for word expressions concerning their reasons for entering or remaining in treatment were recorded by the investigator after informal interview.

A measure of the face validity of the items in terms of their reflecting the four dimensions of the CMRS was obtained through judges' ratings. All 52 statements were circulated to 11 staff members (clinical and administrative) who independently rated the degree to which items reflected the 4 dimensions as defined above; all obtained high concordance ratings.

The format of the CMRS is a self report instrument with items stated in first person and responses ranging on a five point Likert-type scale from strongly disagree to strongly agree. The CMRS was implemented as part of a general battery of tests in October, 1984 and since then has been routinely completed at Phoenix House on all admissions within 48 hours of their entry into residential treatment.

RESULTS

Preliminary findings are reported from two analyses. The CMRS correlates of short term dropout (30 days) on all admissions across an 8 month period (October, 1984 - May 31, 1985: N=400); and correlates of short and long term dropout (150 days) on a smaller cohort of admissions (October, 1984 - December, 1984: N=75).

Table 1 displays the significant correlation coefficients between the CMRS items and demography and primary drug. Circumstances (external pressures) did not appear to be a significant correlate of these variables with the exception of sex. Males more often came to treatment under pressures, legal, family, or from relationships. Most correlations occurred with age followed by primary drug, race and the fewest with sex. Generally, lower motivation, readiness and suitability for treatment appeared to be associated with younger clients, whites and primary marijuana abusers. However, interpretation of this large number of significant coefficients awaits clarification from further analyses, particularly of the intercorrelation among the CMRS items.

CMRS Correlates of Short Term Dropout

Table 1 indicates that 19 of the 52 CMRS items (36.6%) were significantly correlated with 30 day retention. None of the items were from the area of circumstance, 4 were in the area motivation and the remainder were in the areas of readiness and suitability. These results indicate that rather than external pressure (e.g. family or legal circumstances) motivation, readiness and suitability for residential treatment appear as correlates of short term retention.

Phoenix House

TABLE 1

ADMISSIONS OCTOBER 1, 1984 - MAY 31, 1985
N < > 400

CORRELATIONS OF CIRCUMSTANCE, MOTIVATION, READINESS & SUITABILITY VARIABLES WITH DEMOGRAPHY, PRIMARY DRUG, AND RETENTION

	Sex	Age	Black	White	Hisp	Heroin	Coca.	Marij	PCP	30 Days TIP
Circumstance										
C1. (sure I would go to jail)	-.18***	-	-.15**	.10*	-	.21***	-.14**	-	-	-
C2. (afraid of being in jail)	.16**	-	-	-	-	-	-	-	-	-
C3. (would have come without legal pressure)	-	-	-	-	-	-	-	-	-	-
C4. (family pressure to get help)	-	-	-	-	-	-	-	-	-	-
C5. (family would not let live at home)	-	.17***	-	.11*	-	-	-	-	-	-
C6. (rel. will leave if don't come into tr.)	-.18***	.10*	-.11*	.11*	-	-	-	-	-	-
C7. (rel. will try to make me leave tr.)	-	-	-	-	-	-	-	-	-	-
C8. (sure rel. will stay with me until comple.)	-	-	-	-.11*	-	-	-	-	-	-
C9. (will have serious money problems if I stay)	-.14	-	-	-	-	-	-	-	-	-
C10. (many outside problems will prevent comple.)	-	-	-	-	-	-	-	.12**	-	-
C11. (don't need tr., here because of pressure)	-	-.18***	-.13**	-	-	-	-	-	-	-
Motivation										
M1. (would have come without family pressure)	-	.16**	.12**	-.11**	-	-	.11*	-	-	-
M2. (will stay even if rel. wants me to leave)	-	.11**	-	-	-	-	.10*	.11*	-	.11*
M3. (my drug use is a very serious problem)	-	.17***	-	-	-	.14**	-	-.18***	-	.13**
M4. (drug use has caused variety of problems)	-	.12**	-	-	-	.10*	-	-.14**	-	-
M5. (can get life together even if use drugs)	-	-.13**	-	-	-	-.15**	-	-	-	-
M6. (have to stay off drugs to get what I want)	-	.10*	-	-	-	-	-	-	-	.13**
M7. (often don't like myself because of drugs)	-	.19***	-	-	-	-	-	-.12**	-	.11*
M8. ("getting high" is no problem for me)	-	-.13**	.10*	.10*	-	-.19*	.15**	-	-	-
M9. (lately, I feel I can't control my life)	-	.10*	-	-	-	-	-	-	-	-
M10. (feel I've lost everything due to drugs)	-	.24***	-	-	-	.13**	-	-.12**	-	-
M11. (if I don't change, life will get worse)	-	.16**	.11*	-	-	-	-	-.18***	-	-
M12. (afraid I'll end up dead if I don't stop)	-	.14**	-	-	-	-	-	-.16**	-	-
M13. (will have to make real changes)	-	-	-	-	-	-	-	-.14**	-	-
M14. (feel bad about hurting people)	-	.10*	-	-	-	-	-	-.19***	-	-
M15. (more imp. than anything else is to stop)	-	.14**	.13**	-.21***	-	-	-	-	-	.10*
M16. (life is ok, but have to make some changes)	-	.10*	.11*	-.18***	-	-	-	.12*	-	-
M17. (need help in areas other than drugs, also)	-	-	-	-	-	-	-.10*	-	-	-

	Sex	Age	Black	White	Hisp.	Her. Coc.	Mar.	PCP	30 Days TIP
Readiness									
R1. (don't need treat.,can stop if I want)	-	-.11*	-	-	-	- -	.11*	-	-.18***
R2. (came to PH because ready to deal w. myself)	-	.13*	.23***	-.18***	-.10	- -	-	-	.15**
R3. (will do whatever I have to)	-	-	-.16***	-.12**	-	- .11*	-	-	.10*
R4. (see no other choice for help except treat.)	-	.18***	-	-	-	- -	-.13**	-	.14**
R5. (can't stop drugs with S.O. or religion)	-	.13**	-	-	-	.10* -	-.14**	-	-
R6. (if can't get help here, will go elsewhere)	.10*	.24***	.17***	-	-.13**	- -	-.12**	-	.10*
R7. (tired of drugs, know can't change on own)	-	.20***	-	-	-	.10* -	-.12**	-	.17**
R8. (willing to enter treat. soon as possible)	-	-	-	-	-	- -	-	-	
Suitability									
S1. (willing to sever family ties for a while)	-	.15**	.13**	-.10*	-	- -	-	-	-
S2. (willing to sever street ties for a while)	-	.18***	-	-	-	- -	-.11*	-	.12**
S3. (PH type of program seems right approach)	-	-	.11*	-.11*	-	- -	-.12**	-	.23***
S4. (need long period in new environ. to change)	-	-	.10*	-.15**	-	- -	-.14**	-	-
S5. (need to change attitude as well as behav.)	-	-	-	-	-	- -	-	-	-
S6. (need to be drug free to live success.)	-	.13**	-	-	-	- -	-	-	-
S7. (don't think can adjust well to PH)	-	-.13**	-	-	-	- -	-	-	-.15**
S8. (some other kind of treat. more helpful)	-	-	-	-	-	- -	-	-	-
S9. (means a lot of sacrifice to stay)	-	-	-	-	-	- -	-	-	-
S10. (don't feel my problems serious enough for PH)	-	-	-	-	-	- -	.11*	-	-.14**
S11. (will stay in PH as long as I have to)	-	.13**	-	-.12**	-	- -	-.16**	-	.18***
S12. (drug use is only part of my problem)	-	-	-	-.10*	-	- -	-	-	.13**
S13. (have to avoid people & places with drugs)	-	-	-	-	-.12**	- -	-	-	-
S14. (have tried other treat.,hasn't helped much)	-.16**	.11*	-	.12**	-	- -	-	-	-
S15. (can't help myself at home; need to be in PH)	-	.13**	-	-.24***	-	- -	.10*	-.24***	-	.21***
S16. (have fears about being in place like PH)	.16***	-	-	-	-	- -	-	-	-

* p .05
** p .01
*** pp .001

PRIVACY HOLDS

TABLE 2

COHORT 1: SINGLE ADMISSIONS OCTOBER 29, 1989 - DECEMBER 17, 1989

CORRELATIONS OF CIRCUMSTANCE, MOTIVATION, READINESS & SUITABILITY MEASURES WITH DEMOGRAPHY, PRIMARY DRUG, AND RETENTION

	N< > 75									30 days	90 days	180 days
	Sex	Age	Black	White	Other	Heroin	Cocaine	Marij	PCP	729	729	499
Circumstance												
C1. (more I would go to jail)	-	-	-	-	-	.09***	-	-	-	-	-	-
C2. (afraid of being in jail)	.09*	-	-	-	-	-	-	-	-	.12***	.14***	.17***
C3. (would have come without legal pressure)	-	-	-	-	-	-	-	-	-	-	-	-
C4. (family pressure to get help)	-	.10*	-	-	-	-	-	-	-	-	-	-
C5. (family would not let live at home)	-	-	-	.10*	-.13*	-	-	-	-	-	-	-
C6. (rel. will leave if don't come into tr.)	-.12**	-	-	-	-	-	-	-	-	-	-	-
C7. (rel. will try to make us leave tr.)	-	-	-	-	-	-	.09**	-	-	-	-	-
C8. (more rel. will stay with us until comple.)	-	-.12**	-	-	-	-.10*	-	-	-	-	-	-
C9. (will have serious money problems if I stay)	-	-	-	-	.10**	-	-	-	-	-	-	-
C10. (many outside problems will prevent comple.)	-	-	-	-	.09*	-	-	-	-	-.11**	-.11**	-.12**
C11. (don't need tr., have measure of pressure)	-	-.09*	-.10***	-	-	-	-	-	-	-	-	-
Motivation												
M1. (would have come without family pressure)	-	-	.09*	-	-	-	-	-	-.11**	-	-	-
M2. (will stay even if rel. wants us to leave)	-	-	.10*	-	-	-	-	.11***	-	-	-	-
M3. (my drug use is a very serious problem)	-	.14**	.10*	-	-	-	-	-	-	-	-	-
M4. (drug use has caused variety of problems)	-	-	.11*	-	-	-	-	.13*	-	-	-	-
M5. (can't live together even if use drugs)	-	-.11**	-	-	-	-	-	.13*	-	-	-	-
M6. (have to stay off drugs to get what I want)	-	-	-	-	.10**	-	-	-	-	-	-	-
M7. (often don't like myself because of drugs)	-	.10*	-	-	-	-	-	-	-	.14**	.15**	.16**
M8. ("getting high" is no problem for me)	-	-.14**	.11**	.10*	-	-.10***	.10***	-	-	-	-	-
M9. (lately, I feel I can't control my life)	-	-	-	.09*	-	-	-	-	-	.11*	-	-
M10. (feel I've lost everything due to drugs)	-	.11***	-	-	-	-	-.13*	-	-	-	-	-
M11. (if I don't change, life will get worse)	-	-.11**	.10***	-.11**	.09*	-	-	-	-	-	-	-
M12. (afraid I'll end up dead if I don't stop)	-	.11**	.11**	-	-	-	-	-	-	-	-	-
M13. (will have to make real changes)	-	-	-	-	-.12**	-	-	-	-	-	-	-
M14. (feel bad about hurting people)	.10*	-	-	-	-	-	-	-	-	-	-	-
M15. (more imp. than anything else is to stop)	-	.11**	.12***	-.12***	-	-	-	-.12***	-	.11*	-	-
M16. (life is ok, but have to make some changes)	-	-	-	-.11*	-	-	-	.11*	-	-	-	-
M17. (need help in areas other than drugs, also)	-	-	-	-	-	-	-	-	-	-	-	-

										? I Mdays)		
Readiness	Sex	Age	Black	White	Male	Heroin	Cocn	Marij	PCP	30	90	180
R1. (don't need tr., can stop if I want)	-	.10*	-	-	-	-	-.11*	.11**	-	-.10***	-.12***	-.11**
R2. (came to PH because I'm ready to deal w/myself)	-	.11***	.13***	-.11**	-.10***	-	.14***	-.11**	-	-	.11**	.11*
R3. (will do whatever I have to)	-	.10*	.11***	-	-.11**	-	.10*	-.14***	-	-	.11**	.11**
R4. (see no other choice/for help except tr.)	-	.11***	.10**	-.10*	-	-	-	-.11**	-	.10*	.10*	.10*
R5. (can't stop drugs with S.O. or religion's help)	-	.14**	-	-	-	-	-	-.11**	-	.10***	-	.10**
R6. (if can't get help here, will even it alone.)	-	.10***	.11**	-	-	.10*	-	-.10*	-	-	-	-
R7. (tired of drugs, know I can't change on own)	-	-	.10*	-	-	-	-	-	-.10*	-	.10*	-
R8. (willing to enter tr. as soon as possible)	-	-	-	-	-.10*	-	-	-	-	.09**	.11**	.11**
Suitability												
S1. (willing to accept family ties for a while)	-	.10***	.11***	-.11***	-	-	-	-.10***	-	-	.10*	-
S2. (willing to accept street ties for a while)	-	.10***	.10*	-	-.10*	-	-	-.11*	-	-.11**	.11*	-
S3. (PH type of prog. seems to be right approach)	-	-	.11**	-	.10*	-	-	-	-	.10***	.11***	.11**
S4. (need long period in res env. to change)	-	-	.10***	-.11***	-	-	-	-	-	-	-	-
S5. (need to change attit. as well as behav.)	-	-	.10*	-.10 **	-	-	-	-	-	-	-	-
S6. (need to be drug free to live successfully)	-	-	.09*	-.11**	-	-	-	-	-	-	-	-
S7. (don't think I can adjust well to PH)	-	-.10*	-.11***	-	.11**	-	-	-	-	-	-	-
S8. (some other kind of tr. would be more helpful)	-	-	-	-	-	-	-	-	-	-	-	-
S9. (know it will mean a lot of sacrifice to stay)	-	-	-	-	-	-	-	-	-	-	-	-
S10. (don't feel my problems serious enough for PH)	.11**	-	-	-	-	-	-	-	-	-	-	-.10*
S11. (will stay in PH as long as I have to)	-	.11*	.10***	-.11**	-	.10*	-	-.11**	-	.10**	.11***	.10**
S12. (drug use is only part of my problem)	-	-	.11**	-.10***	-	-	-	-	-	-	-	-
S13. (have to avoid people and places w/drugs)	-	-	.10***	-	-.10***	-	-	-.11*	-	-	-	-
S14. (have tried other tr. and hasn't helped much)	.10*	-	-	.09*	-.11**	-	-	-	-	-	-	-
S15. (can't help myself at home; need to be in PH)	-	.09*	.11*	.09*	-	-	.11*	-.11***	-	.11**	.11*	.09*
S16. (have fears about being in a place like PH)	-	-	-	-	-	-	-	.10*	-.11*	-	-	-

* P < .05
** P < .01
*** P < .001

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CMRS Correlates of Long Term Retention

Table 2 contains the significant correlations of the CMRS items, with 30, 90, and 150 day retention for a smaller cohort of admissions. Overall, a constant 25% of the CMRS items were significant correlates of 30, 90, and 150 days retention. Focusing on long term (150 days) retention, 2 of the items were in the circumstantial area, 1 from motivation and the remainder were in the areas of readiness and suitability.

The results in Table 2 indicate that the same CMRS items persisted as correlated of both short and long term dropout. For example, most of the significant CMRS correlated of 30 day retention remained significant for 90 and 150 day retention; the others were the same correlates of 2 points in time. Thus, about a quarter of the CMRS items were significantly correlated with short term retention, practically all of which were persistent correlates of longterm retention.

DISCUSSION

Although preliminary, the present findings are impressive in showing a consistent association between self report statements that purportedly measure motivation, readiness, or suitability for therapeutic community treatment and short and long term dropout. Thus, the CMRS appears to have clinical utility since it has potential for identifying clients who are "at risk" for early dropout. Although such high risks clients may hot necessarily be screened from treatment, they can be better prepared for the therapeutic community experience during the admission process or in their orientation phase. Clinicians can be alerted to focusing on such issues of denial (motivation), reducing resistance to treatment (readiness), and role induction (suitability).

The CMRS also has implications for research and theory. For example the present results accord with the perspective on retention elaborated in other writings (e.g. De Leon, 1984) and outlined in the introduction to this paper. Briefly, retention in treatment reflects a complexity of factors, related to the client, treatment and non-treatment conditions. With respect to the client factors, however, the present results emphasize the importance of how clients see themselves and their options during their involvement with treatment. Perception of the severity of their problems, needs for treatment and their acceptance of particular treatment alternatives appear to directly relate to their tenure in treatment.

These perceptual factors, however, may be linked to "fixed" client characteristics such as those associated with age. For example, in this and in previous research, age is not a predictor of dropout, although age is known to correlate with length of addiction, fatigue with the drug lifestyle and attempts to stop drug usage. The present results indicated that motivation, readiness and suitability, correlated with both age and dropout. Thus, rather than age alone, these age associated characteristics may lead to changes in motivation and readiness which in turn correlate with retention in treatment.

That the CMRS correlates of short and long term retention were the same items remains to be explained. For example, research has established that the longer clients remain in treatment the greater the likelihood that they will continues to remain in treatment (e.g. De Leon and Schwartz, 1984). This likelihood of staying in treatment somewhat clouds the specific contribution of the CMRS factors to long term retention. Perhaps initial readiness and suitability are correlated with short term treatment, after which program influences combine with or enhance these factors to sustain longer term retention in treatment. This hypothesis is currently under investigation in Phoenix research. However, the persistence of the CMRS factors over time may illuminate why clients drop out of treatment. For example, research indicates that short term and long term dropouts leave treatment for different reasons. (De Leon, 1984; Jainchill et al, 1985; Craig, 1984). The present findings suggest that although the explicit reasons for dropout may vary over time, these may influence, or be influenced by, motivation, readiness and suitability which appear as the consistent correlates of retention.

Given the experimental status of the CMRS, the present findings and conclusions must be interpreted with caution. The magnitude of the coefficients are low to moderate; and their was a high degree of intercorrelation among the items which suggests that the number of statements can be considerably reduced. Moreover, further analysis will clarify the independence of these four dimensions. For example, whether motivation and readiness constitute distinctly different areas is not firmly demonstrated. The present instrument is currently under revision to satisfy these issues as well as psychometric and pragmatic considerations.

Nevertheless, these orderly results obtained on a large sample of admissions confirm the widely held clinical view of the importance of motivation, readiness and suitability in successful treatment. Thus, the CMRS appears to be a promising tool for assessment, treatment planning and research in therapeutic communities.

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JUVENILE DRUG ADDICTION: A STUDY ON TYPOLOGY OF ADDICTS AND THEIR FAMILIES

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Objectives

There was a time when drug addiction was limited to a specific social group, or to individuals whose deviant behavior was already patent before they took to drugs. But now dependence on heroin (and, most recently, cocaine) involves an important proportion of the juvenile and adult population of Italy.

The relative ease of access to drugs has led to a situation in which drug dependence covers, masks, and partially compensates for a wide range of personal and family problems.

In previous papers some of us presented a tentative classification that related drug addiction to there problems. Four main categories or syndromes of drug addiction emerged:

A. Traumatic drug addiction
B. Drug addiction from actual neuroses
C. Transitional drug addiction
D. Sociopathic drug addiction

These categories grew out of research undertaken from several different approaches: a) the study of the organization and the modes of communication of the families of drug addicts; b) the observation and description of the behavior of the drug addicts themselves; c) the evaluation of the personal problems of drug addicts, from a psycho-dynamic perspective; and d) the evaluation of the practical effects over time of different therapeutic strategies.

Elsewhere we have discussed the problems raised in combining data gathered using such different points of view. In this paper we will deal primarily with data derived from a population of 103 drug addicts treated by a group of therapists with a systemic/relational approach.

We have included in this statistical population only those subjects who began treatment in 1982 and who had finished treatment (or interrupted it) by June, 1984, when the follow-up study was made.

There was no "filter" imposed on persons who made the initial request for help. Nor was it required that addicts be present at the first interview with persons involved in their problem. The interview was centered on the present situation of the addict, her/his family, friends, and previous therapies. This information was in turn presented by the therapist to a discussion group, which decided on the best approach: a) family therapy; b) individual support; c) network therapy; d) counseling focused on the possibility of getting the addict to enter a therapeutic community. In 28 cases these procedures failed (18% of the total requests for help) and the addict refused treatment. These addicts have not been included in the population studies here.

Following a decision made at the beginning of the research, two different types of family therapy were used, depending on the attitudes of the families involved. The model proposed by Haley and by Stanton and Todd (which we will refer to as "structural" family therapy) was applied when the therapists had the impression that the family reacted strongly to them and assumed a clear position in regard to the drug addiction. On the other hand, a "paradoxical" strategy was used when the therapists perceived a weak, disorganized, and confused reaction from the family, seemingly unable to take a stand in regard to the symptom and its consequences.

While the first interview was made by a single therapist, the family therapy sessions were always conducted by two therapists. On request, the team could receive the external supervision of an expert in family therapy. When necessary, drug withdrawal took place in the home of the patient, with the active

involvement of the family. The therapists themselves provided the medical and psychological home support necessary in this phase. At the beginning of treatment, family therapy sessions were held weekly; and when the therapy was advanced, monthly. The therapeutic setting was flexible, and the therapists would meet with the family at the family's request if something new came up. The average length of therapy was about a year, and counseling took place in up to four sessions. The study was conducted in a private center (Albedo Center) and the cost of the therapy was partly covered by a subsidy from the Lazio Region Administration.

A research group discussed the organization of clinical, therapeutic, and follow-up data. The assignment of individual cases to the four categories of addiction was made by researchers on the basis of information provided by the therapists, using a schedule drawn up in the context of a wider study of the typology of drug addiction.

In Table 1 we have included: a) the distribution of the 103 drug addicts studies, with their families, in the four categories of the classification; b) the kind of therapeutic program adopted; and c) the outcome of the therapy.

The table shows clearly the following:

a) There is a relation between the categories of addiction and the therapies proposed; therapists employ family therapy in the addictions of type B ("actual neuroses") and C ("transitional"); offer individual support to "traumatic" addictions (type A); and organize a network therapy or assignment to a therapeutic community in the case of sociopathic addictions (type D).

b) There is a significant correlation between the cases in which the therapists decided to employ a paradoxical strategy and the cases classified as type C ("transitional"); the reasons for their decisions will become clear in the following discussion.

Traumatic Drug Addiction

The family contexts for this kind of addiction are rather varied. In some cases the patients have been "model" sons or daughters, who kept to themselves their own problems (accustomed as they were to resolving the problems of others) and gave way to addiction in the face of a serious trauma. In other cases, the patients are persons who have only recently gone through the phase of individuation or separation: the trauma threatens their equilibrium in a period in which their earlier relationships no longer provide adequate support and their new ones are still too precarious to ensure a point of reference. Such persons may be adolescents who have only recently defined their own identity or young adults not yet involved in deep relationships or only recently members of a couple, whose new network of relations in inadequate at the time of need caused by sorrow and mourning. A sense of guilt, often present in the experience of mourning, is easily linked in these adolescents or young adults to the effort of emancipation from the family nucleus in stressful circumstances.

Clinically, we can identify three elements that characterize this kind of drug addiction:

a) The way the addiction develops: whether it is the result of a first contact with the drug or the transformation in addiction of a drug use previously controlled, the break with the normal pattern of life occurs quite rapidly, and heroin suddenly becomes the center of attention, protecting the individual in a state of panic.

b) Aspects of the habit: the addict is autodestructive and theatrical, uses alcohol and barbituates in addition to heroin, seeks numbness rather than pleasure, increases dosage rapidly, and is at high risk for overdoses.

c) The importance of being in bad shape: from a certain point on, the addict may use withdrawal symptoms caused by abstinence, harm to the body causes by drug abuse, and societal disapproval to cover or mask the sense of guilt provoked by the trauma.

Note that there is no significant correlation between this kind of addiction and the kind of drug used. And that in spite of its dramatic nature, these kinds of addiction often respond well to therapy. Recovery is total if the drug has not caused permanent physical damage.

From a therapeutic viewpoint, it is fundamental to build a significant relationship with the type A addict. This relationship may be mediated, in some cases, by the prudent short or long-term use of a substitute drug. The thematization and verbalization of the mourning must be reference points of a discourse which rapidly moves from the drug to the person. It is risky, in this kind of situation, to involve

TABLE 1.

Drug addicts beginning treatment in the Albedo Center in 1982. The numbers in parentheses indicate the percentage of subjects whose improvement was stable after 18 months after the end of successful therapy.

Type of Addiction	Family Therapy		Network Therapy	Individual Therapy	Total	Counseling
	Structural	Paradoxical				
Traumatic (A)			1 (100)	3 (66)	4(75)	
Neuroses (B)	49-(63)				49(63)	2
Transitional (C)	11 (36)	22 (73)			33(61)	2
Sociopathic (D)			3 (33)		3(33)	10
Total	60 (57)	22 (73)	4 (50)	3 (66)	89(67)	14

directly the original family, for by centering attention on the current conflict, it may impede the elaboration of the mourning. In our experience it is rarely necessary to have recourse to live-in therapeutic programs.

The Case of Mario. Mario began the use of heroin at age 20, a few months after the death of his father and the discovery that his older brother was seriously ill. After an initial "high" phase, a dramatic experience linked to an overdose marked both the most acute point in the addiction and the beginning of a critical reflection of his situation. Various attempts at withdrawal by means of other drugs were unsuccessful. The effective therapy began with withdrawal at a walk-in clinic using symptomatic drugs under the direct daily control of the therapist, who set up with Mario an intense, significant relationship. The second part of the therapy involved the verbalization and elaboration of the recent experience of loss. With the support of the therapist, Mario slowly began to reorganize his life: he met in a new way situations of "risk" (meetings with his addict friends, his difficulty in his relations with his fiancee, etc.) without falling back into addiction. After six years, Mario is working, leads a satisfying life, and has not gone back to drugs.

The Case of Franco. When he was 17 years old Franco was in an automobile accident and his father died in his arms in the ambulance on the way to the hospital. His drug use began within a few days and within a year Franco felt he had "touched the bottom." He succeeded in giving up drug use for three months while he lived in his girlfriend's house, but as soon as he returned home he took up heroin again The therapy began by involving Franco's mother and brother. But after three sessions in which accusations and reciprocal misunderstandings prevented the therapists from getting at the problems related to the family's recent trauma, Franco's mother did not want to come any more, and Franco himself rejected the presence of his mother and brother. A new period of total involvement with the drug led him to seek help again, and this time the therapist proposed an individual therapy. Attention was centered on the anguish caused by the violent loss of his father and his admission of a feeling of guilt for not being able to avoid the accident. These feelings had been repressed and denied for more than a year during the addiction. At the same time, the therapist provided personal support, involving the fiancee as well, to help Franco land a job through an open competition. Four years after the end of the therapy, Franco has held his job, uses heroin no longer, and has gone to live with his girl.

Drug Addiction from Actual Neuroses

Actual neurosis is characterized by the existence of active conflict around the subject that is more important than infantile conflict in defining the symptomatic description (feelings of inadequacy/incapacity, depressions, various idiosyncrasies, a waning in activity and interests, demonstrative behavior). Its reality has been questioned by some modern psychoanalysts, but its clinical presence is indisputable for those who treat drug addicts and their families.

The family structure in which this kind of drug addiction develops has been repeatedly described by family therapists who have worked with addicts. In systemic and family terms in involves:

a) the deep involvement of one of the parents (generally that of the opposite sex) in the life of the daughter/son and her/his "sickness";

b) the peripheral role of the other parent;

c) the presence of a structure known as the "perverse triangle";

d) the weakness of boundaries between the subsystems that made up the family hierarchy;

e) the development of a polarity that defines the addict child as "bad" as compared with another "good" child;

f) a system of communication characterized by contradictory (not paradoxical) messages and conflicts that develop with rapidity and violence.

There are obvious parallels between these families and those of young delinquents and of children with psychosomatic symptoms or slight behavioral problems.

From a clinical point of view, type B addictions (above all seen in the clinics where methadone is given to addicts "dissatisfied" with any kind of therapy) are depressive in nature (addicts do not obtain pleasure from drug use) and involve a demonstrative stance. Addictive behavior is alternately a pained defiance or an intolerance involving a direct provocation of those persons perceived as responsible (generally parents, but often as well the therapists and others who seek to help).

From the therapeutic viewpoint, efforts must be directed from the very start toward the control of symptomatic behavior by means of the establishment of a united front on the part of the parents and/or other adults available to help. For accurate descriptions of the problems involved with this kind of addiction and possible solutions, the work of Stanton and Todd and Alberdo may be consulted. Here we wish to note only that with this kind of intervention, it is possible to undertake the withdrawal at home.

Generally, it is useless to work individually with these addicts. Time in a therapeutic community may be decisive (although not always necessary), but only when the therapy involves both parents.

The Case of Marco. Marco's addiction involved dramatic acting out within the family: attempted suicides, thefts from home, incidents connected with the injection of the drug. His mother became so concerned that at times, after threats of suicide, it would be she who actually did the injecting. Prior to the addiction, Marco's parents had threatened to separate, and conflict was frequent in the family.

In the first phase of therapy it was decided to give the father the authority to set the rules Marco would have to obey during home withdrawal. The mother was to collaborate with the father. Marco's father, until then completely peripheral, for the first time succeeded in demonstrating his strength and taking control over his son. The therapists, called urgently to the home, witnessed an all-out struggle between Marco, who threatened to jump out the window in order to have the drug, and his father, who succeeded in not giving it and in blocking Marco's behavior. After withdrawal, the therapist began on the one hand meetings with Marco and his girlfriend (to consider setting up a new life) and on the other with his parents (to work on the marital conflict and its symptoms that appeared in the mother when the addiction of the son was under control). In the following ten years, Marco has not gone back to drugs and had led a satisfying life.

Transitional Drug Addiction (Type C)

Glover has studied drug addictions in which the defense mechanism of the addict has a typical "transitional" form. That is, the psychotic and neurotic components (especially obsessive, depressive, or paranoid) interact in a complex way and present a clinical description whose evolution is similar to other kinds of manic-depressive psychoses. This kind of addiction has the following characteristics:

a) Powerful, repeated, manic states, particularly in young heroin addicts: the addict lives a "honeymoon" and experiences sudden and pleasing effects from the drug; drug use relieves specific personal sufferings that existed long before the encounter with the drug, and which emerge in a careful enquiry; "one is struck," claims Olievenstein, "by the totalitarian description, very close to ecstasy, of the first flash... an incomparably revelation, unity obtained once more, the atmosphere of joy..."

b) Powerful, repeated, depressive states (particularly frequent and stable on adult addicts), with a corresponding ritualistic, compulsive, destructive, and obtuse addictive behavior: importance is placed on the need to be continually numbed, rather than on the pleasure by the effects of the drugs consumed;

c) overall, difficulty on the part of patients, their parents, or outside observers in linking the evolution of the addiction to specific events in the life of the addict; it is not unusual, for instance, for the habit to have begun "when things were going well" or for it to be interrupted when damage to the body or specific pains take over from the negative effects of the drug;

e) a long-term risk of backsliding, sometimes in the form of alcoholism, on the part of those considered "cured".

In our experience, the organization and communicative style of the families where this kind of addiction is present show interesting analogies with those of families of anorexics.

a) The effort not to define relationships is maintained by frequent (but not obligatory or continuous) use of paradoxical and incongruous messages (for instance, returning to the habit as a response to the proposal of therapy, depressive or paradoxical resistance to therapeutic sessions, etc.); there is a high level of mystification both within the family and in its contacts with the outside, which renders the information it gives of questionable value, and makes the overall atmosphere or ambiance more significant.

A detailed discussion of this argument does not seem appropriate here. We would like to emphasize, however, in reference to the connection between this kind of personal problem and the communicative dysfunction of the family, its relevance in leading one to question the point of view of parents who seen the addiction as the result of an unredeemable immaturity on the part of the child incapable of acting in her/his own best interests. It is precisely this kind of conviction or motivation, whose incongruity is matched only by the fervor by which it is maintained, that appears to inspire the two extremes of "the coercive therapeutic

community" and "controlled administration of heroin", which have provoked so much controversy in recent years.

b) members show a diffuse tendency to ignore the meaning of the messages of the others and to use the illness in order to resolve the problem of leadership, taking a stance of self-sacrifice.

There are also, however, differences between these families and those of anorexics:

a) In these families there is a tendency to draw in and manipulate therapists, friends, and relatives in family matters in order to strengthen their own positions;

b) In these families there is a tendency to act out repeatedly very intense, but brief scenes (as with conflicts between parents that often end in incomplete separations).

These parents (whose relation is only sometimes that of the symmetrical "hubris" of psychotic families) are both involved in the addiction or private life of their offspring. The polarity between the sons is not that of good/bad as in type B, but rather that of success/failure. Often in this kind of family, as in those with a psychotic patient, there is a person whom Mara Selvini has called the "prestigious member": a sibling who, for a variety of reasons, enjoys a prestige in regard to brothers and sisters. This figure commonly is affectively involved in the problems of the family; feels more competent in resolving them, and has a long history of intimacy with one of the parents." At the time of detachment of the prestigious member, "the behavior of the patient, far from that of dislodging the annoying brother from a situation that had become insufferable, has the effect of fixing things as they are."

The therapist dealing with this kind of situation may try to oppose resolutely the addictive behavior, redefining it as an extreme manifestation of a more important interpersonal problem and working swiftly to control the symptoms. But in our experience, the therapist must protect against returns to drugs by taking an attitude and making redefinitions that can later be used with a paradoxical strategy.

In other cases (like that reported below), the therapist may decide to follow a paradoxical therapeutic strategy from the start.

The Case of Sandro. Age 23, Sandro has been an addict for seven years already. Recourse to methadone and other treatments had no positive effects. Three persons came to the first family therapy session: Sandro, his mother, and Lisa, his 18 year old sister. His father had died many years earlier. With an air of tragedy, the mother complained about the money her son extorted from her daily. Sandro, who did not like to talk about his addiction which he experienced "as an annulling of all thought and feeling," said that his mother did not understand him. Lisa said there was nothing she could do and talked about the repercussions on her private life of her brother's problem. The therapists, emphasizing the absence of a common goal, asked for time to think over the possibility of beginning therapy, in order not to raise false illusions. The family reacted sharply to this provocation, telephoning several times to obtain a new appointment.

The therapists decided to use a paradoxical strategy, one which included the use of "sculptures" as proposed by P. Caille. during the first session, the sculpture ought to illustrate, according to each person's point of view, what happens in their daily relations. In the second session, each person should use a "mythic" symbolic image for the trait that makes their family unique and original. The elements çproposed at this point are those to be used in the final paradoxical intervention, but in the meanwhile the therapy is based on the content of the first phenomenological sculpture. A certain number of sessions were used to discuss individually with members of the family the possibility of adding "new elements" to the normal interactions of the family. Apt suggestions accepted, but not put into practice by each family member, were used by the therapists to force each person to confront her or his incapacity for making even small changes. This facilitated a return to the elements of the "mythical" sculpture to propose the paradoxical intervention. One of the therapists explained to the family why it was better to maintain their present equilibrium without pushing for change. Even the addiction was redefined as essential for maintaining what seemed to be the system's best equilibrium. The other therapist, however, said he did not agree. Sandro, in his opinion, did not want to continue to sacrifice himself; Lisa wanted to get away from home; their mother, free of the kids, would have finally been able to think of herself. The struggle caused by this intervention lasted several months and permitted a therapy which challenged the system of the family and an acceptance of personal experience. A year after the first therapeutic session Sandro has stopped using heroin and has found a job.

Sociopathic Drug Addiction (type D)

This kind of addiction is frequently found in the kind of person who expressed psychic conflict by acting it out. Such persons typically share the following traits or histories:

a) known antisocial behavior prior to drug addiction, particularly in adolescents and young adults who live in conditions of social and cultural disadvantage;

b) a rapid and natural assimilation of drug addiction within a lifestyle adapted to drug use, but which takes on a caricature-like aspect when the habit becomes addiction;

c) the defiant attitude of the addict, who acts with the coldness and the provocation of someone "unable to love and accept love", and who sees the environment as cold and hostile, relieved only by the occasional volunteers who enter his/her life in the role of providential "saviors";

d) the detachment with which the addicts speak of their habits; the anaesthetic numbness of the sensations sought from drug use; the frequency of multiple drug-use; and the underestimation of the effects of the drug (which include permanent bodily harm).

Typically these addicts are the children of economically and culturally deprived women, who have abandoned them in the state institutions; or (often the two types overlap) children of multiproblem families in the ghettos of the big cities. The maladaptation of these youths is evident first in difficulties in school, and later, in adolescence, in the progressively increasing violence with which they react to the rules of a society perceived from their delinquent subculture as cruel and hostile. There are other cases in which economic and cultural difficulties are not so obvious.

The communicative model and organization of the families of addicts of this type resemble, in the less serious cases, those of the families of addicts due to present neuroses. But in the more serious cases the resemblance is greater with "detached" families. Such families, normally from the most disadvantaged social classes, but occasionally from middle or upper classes, are profoundly and dramatically disorganized, human groups whose members seem to move in isolated orbits without any apparent reciprocal interdependence.

Many of the more serious addicts are marked by the experience of total abandonment in early childhood, and many of the others had an early childhood marked by family problems. entional therapy are in these cases rare and difficult. Nevertheless, one notes, looking at the life histories of those addicts who have broken their habit, that it may be that the combination of a series of therapeutic spells may produce surprising results. These are, up to now, somewhat spontaneous trajectories which are worth studying. An addict who has been able to stop shooting up first went to a methadone maintenance clinic, had good rapport there with a technician, then went to conventional therapy are in these cases rare and difficult. Nevertheless, one notes, looking at the life histories of those addicts who have broken their habit, that it may be that the combination of a series of therapeutic spells may produce surprising results. These are, up to now, somewhat spontaneous trajectories which are worth studying. An addict who has been able to stop shooting up first went to a methadone maintenance clinic, had good rapport there with a technician, then went to live in a therapeutic community, which he left to join another, "more appropriate" one, and finally joined a craftsman's cooperative. An attentive study of similar stories, far from demonstrating the unusefullness of the various therapies, suggest that in these cases a "therapeutic chain" might well be organized in which more therapeutic approaches might cooperate, each one representing a significant step toward change.

The therapeutic community is particularly useful in these cases as the final stage. It (and sometimes it alone) can fill the vacuum of social and family relations, receiving the person in a group in which to deal with the anguish caused by different kinds of suffering. In some cases, special techniques aimed at the system may be applied (like those described by MacGregor for multiproblem families, and Judith Landau for disadvantaged families).

The Case of Fabio . Soon after emigrating, Fabio's father had effectively abandoned his family. His mother, who was alcoholic, had lost legal custody of her children, who had become wards of the children's' court. After growing up in various institutions, Fabio began his life in the streets. Through heroin he achieved his desire to "lose himself." He used very high doses, smoked hashish, shut himself off from the world, and became ever more depressed. He lived by stealing and was part of a group of delinquents. after a few attempts at withdrawal with methadone in a clinic, he went with a friend to a community. It was hard for him to adapt to the rules, and it was decided to make an exception in his case and relax some of the admissions requirements. At the same time he began to take part in group therapy. After two years, he

succeeded in breaking the habit and in starting new life projects. At present, through still in contact with the community, he has a job and a home.

The Case of Franca. Franca, age 25, is separated and has a baby that her husband and her parents-in-law want to take away from her because of her drug addiction, which has lasted for five years. She lived for a while in a community with the child, but as soon as she left she began to shoot up again. At the same time that she approached the Albedo group for therapy, she was getting treatment at a public facility, where she had gotten several staff members concerned with her problems.

Her father, "the only person with whom I've had a good relation," committed suicide when she was seven years old. Her relations with her mother and her sister soon became difficult, and when she was sixteen she left home and never went back. She has lost all contact with her parents. She quickly sought to tie the therapist to her, using her fragility. She said she was unable to deal with any situation, and that the therapist was the only person who could save her. The therapists decided on a strategy of network therapy, involving all the persons who had had significant relations with Franca. To the session came the ex-husband, his family, some women friends, the staff members of the public clinic, and her mother and her sister, called in for the occasion froma foreign country. The support offered to Franca on this occasion made it impossible for her to continue to manipulate the therapist and hide herself behind the mask of fragility and loneliness. She had serious problems to face (her husband had files for custody of their child; she had no job, no house, etc.).

In this way an individual psychotherapy began aimed at facing one by one the problems involved with the different steps Franca would have to take to reorganize her life. After a year she had gotten a job and a house.

Discussion

From the point of view of family therapy, the classification we have proposed leads to several simple suggestions. First of all, the families of drug addicts can't be seen as homogeneous.

Reviewing the literature, it can be deduced that, in our terms, the work of Jay Haley on "crazies," young people when it refers to addicts, centers on families of type B or C. Haley himself underlines the difference between the two types when he refers to problems more or less serious, and when he speaks of one parent involved in the addiction, as opposed to two parents hyper-involved.

Quite similar descriptions are found in the work of Kaufman and Kaufman on the families of drug addicts. And it may be that Stanton and Todd, by choosing families in which the addict accepts long-term methadone treatment, end up dealing especially with type B families, (although it is clear that some of the cases the authors describe are type C).

In accord with our hypotheses about the typology, therapists who are system-oriented can expect some correspondence between the context in which they work and the kind of families they encounter to work with.

Secondly, the typology provides a good perspective about different ways, apparently confusing, that drug addicts are treated. For these differences, both in theory and practice, are so marked, that only two explanations are open: either the different therapies have specific application for certain kinds of drug addicts, or the addicts eventually select out the therapy which best suits them.

The data we have presented support the second of these explanations. From a systemic point of view, it might be that one should think about family therapy as one of several settings in which we need to work with drug addicts. An individual approach, for instance, is preferable with addicts of type A (traumatic), even if a paradigm aimed at the system is used. And it might be that a long-term therapeutic program in a community combined with family therapy is the better solution for addicts of type C (transitional). On the other hand, for addicts of type B (actual neuroses), the ideal might be family-therapy or a short-term program in a community combined with a self-help group for parents.

Finally, the clear and perhaps schematic distinction between families of type B and type C proves very useful when therapists who are systems-oriented have to choose between "structural" or "paradoxical" intervention; following Stanton's distinction, conversion or diversion therapies. Paradoxical prescriptions can be useful, but should be used when problems are quite serious and the family interactions show some level of psychotic communication. That is to say, in terms of our classification:

a) that "structural" family therapy can be used (and is fact is being used, formally and informally, in many settings whether or not they are specifically therapeutic) with families of type B; and

b) that the paradoxical and strategic approach should be adopted when the systems-oriented therapist encounters families of type C, and, less frequently, of type D.

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PREVENTIVE MEASURES

About Condoms, Spermicides, Gloves and Latex Barriers

CONDOMS: Latex (not natural) condoms are known to be effective in preventing other sexually transmitted diseases such as gonorrhea, syphilis, herpes, and chlamydia. Although no studies have been completed to prove that they will prevent the transmission of the AIDS virus, most researchers believe that latex condoms will offer at least some protection.

SPERMICIDES: Nonoxynol 9, the active ingredient in most spermicides (foams, creams, jellies), has been found to kill the AIDS virus in a laboratory dish, although we don't know for sure that it will kill the virus in the body. Many researchers believe, however, that it is a good idea to use a spermicide containing nonoxynol 9 as a backup in case the condom slips or breaks. Some lubricants also contain nonoxynol 9, but may not say so on the label. Check with a pharmacist to be sure. **CAUTION:** Some people are allergic to nonoxynol 9. Test the spermicide on the inside of your wrist before using it. If it stings or you get another reaction, try changing brands. A small amount of spermicide inside the tip of the condom increases sensitivity for the male partner.

DISPOSABLE LATEX GLOVES: If you have cuts or hangnails on your fingers or hands, physicians' disposable latex or rubber gloves will prevent contact with the AIDS virus during hand-genital or hand-anal contact. Gloves can be purchased at any dental or surgical supply house.

LATEX BARRIERS ("RUBBER DAMS"): Some sexologists have suggested that cunnilingus may be safe if done using a latex barrier between the tongue and vulva. This thin piece of latex comes in various sizes and is about the same thickness as a physician's disposable latex glove. Latex barriers come in rolls or sheets and can be purchased at dental and surgical supply houses (they even come with vanilla flavoring). At this time, no research has been done on whether or not they provide protection.

Disclaimer

There is no proof that condoms, spermicides, latex gloves, or latex barriers will prevent the transmission of the AIDS virus. Given the long incubation period, only time will tell if these measures are effective. However, most researchers believe that they offer at least some protection.

For more information call:
The SF AIDS Foundation Hotline at 415/863-AIDS
or COYOTE, 415/552-1849 or 415/381-3606

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AND THE LESBIAN INSEMINATION PROJECT

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